Experiences and perceived effects of participating in the Sisters For Life gender and HIV training intervention in Mahikeng municipality, North West province, South Africa

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Declaration

I, **Lufuno Muvhango**, declare that this research report is my original work. Any work done by other persons has been properly acknowledged in the text. The report is submitted in partial fulfilment of the requirements for the Degree of Master of Public Health with the University of the Witwatersrand, Johannesburg, South Africa. It has not been submitted for any other degree or exam in this or any other University.

Signature: 

Student number: ___0616969E _____

Date: ___18 November 2020____

Abstract

Introduction

Women in South Africa continue to be disproportionately infected by HIV. Biomedical interventions have demonstrated limited efficacy in preventing HIV among women. Intimate Partner Violence (IPV) is a major risk factor for HIV infection among women as it limits their ability to negotiate safer sex. Prevailing social norms continue to undermine behavioural interventions for the prevention of IPV and HIV when implemented alone. Evidence suggests the importance of addressing the underlying gender and economic inequalities as having the potential to effectively prevent HIV infection. However, there is a limited number of such interventions tested in South Africa. The study aims to explore the effects of gender norms and HIV training component of the IMAGE programme by exploring participants' experiences and perceived effects among women who participated in the SFL intervention.

Method

This is a qualitative inquiry undertaken in rural Mahikeng, South Africa. A total of seventeen in-depth interviews were conducted with a purposefully selected sample of 17 women aged between 18–50 years who participate in the SFL component of the IMAGE project between February – December 2016. Data was audio-recorded, transcribed and analysed thematically using word processing software. Ethics clearance was granted from the Human Research Ethics Committee, University of Witwatersrand: Clearance certificate number: M 161191.

Findings

Women described SFL as a valuable training that provides information that is relevant to their lived experiences. They appreciated its participatory activities and facilitators' skills. However, they expressed discomfort over discussing sensitive topics like domestic violence, sexuality and that training facilitation by male facilitators and short duration of the session and lack of referral system undermined SFL platform as a safe space for women to freely discuss such issues.

SFL contributes to retention and adoption of HIV and IPV prevention messages and practices. Women were able to negotiate safer sex and use a condom, test for HIV also with their partners,

disclose HIV status and access treatment. Unlike unmarried women, married women were less likely to report the use of condom; however, some of them were able to test for HIV together with their partners and this facilitated disclosure.

Women became more aware of forms of IPV and some were able to act against IPV with varied level of success. Women experienced violence at the hands of their partners. Younger women (<35 years) were least successful in resolving IPV while older married women or cohabiting women who reportedly successfully addressed IPV with their partners. Problem-solving skills acquired form SFL as well as advice and support exchanged from loan groups were essential to address IPV.

Women found gendered cultural messages and traditional practices to be the underlying cause of IPV experience among women. In addition to alcohol abuse, women attributed social norms and practices such as lobola, bride grooming and accompanying messages in wedding songs and idioms that condone male multiple partnerships and further groom women to tolerate violence as key factors that subjected women to IPV. Women condemned such messages and found them to be unfair and oppressive to women and that they were the main causes of violence within relationships. They further realized that women's use of such messages and engaging in multiple sexual relationships increased the risks of violence from partners and they encouraged fellow women to refrain from such practices.

Participation in the matched economic empowerment programme enabled women to meet needs, and was instrumental to improve financial decision making, shift roles to providers and leaders in the community. However, earning income had limited effect on women's reported sexual decision making and women faced resistance by male partners and resulted in women being complicit with traditional gender roles.

Women reported improved knowledge about sexuality and that it contributed to the adoption of healthy sexual practices. SFL provided accurate information about menstruation and sexuality and enabled women to adopt healthy sexual behaviours like refraining from dry sex and screening for cervical cancer.

However, some of the SFL messages did not lead to a shift in attitudes towards gender norms nor changes in practices. Some women retained attitudes that blame sexual violence on women, and for engaging in transactional sex. They perceive that women should not participate in decision-making, that women should remain responsible for household chores.

Conclusions and recommendations

The study highlights SFL as an valuable, informative and transformative training that is responsive to women's practical life situations However, it is important to ensure that participants are comfortable to discuss sensitive topics freely by ensuring training is delivered by female facilitators. In line with ethical standards, SFL should ensure accessible and well-coordinated referral system as part of the SFL programme to ensure that participants are provided with safe spaces and further support to address recall of painful events related to some of the topics discussed, HIV, disclosure and other challenges that they may be facing in their lives.

The findings confirm that inequitable gender norms embedded in the social and cultural practices influence women's exposure to HIV infection and IPV. The study contributes to the literature that explicates the limited efficacy of biomedical and behavioural interventions in preventing HIV and highlight that interventions to prevent IPV and HIV infection need to prioritize addressing social and gender norms. The study suggests that combining gender and HIV training to economic empowerment is essential for HIV prevention as both gender and economic inequalities contribute to and perpetuate violence against women.

The study further suggests that older women are potential social norms change and HIV prevention brokers within their communities. Women's reflections on how they contribute to enforcing inequitable gender norms as socializing agents for boys and young women (brides) and their ability to challenge and refrain from enforcing inequitable norms, suggest that women are placed at a unique and strategic position to lead social norm change.

Limited shift in attitudes and practices are an indication of the difficulties involved in changing gender norms and highlight the need to strengthen SFL to improve women's agency to challenge and act against gender norms. It further calls for structural interventions to consider involving men or partners to create an enabling environment to women address other areas of their lives that are undermined by male partners including gender roles and sexual decision-making

Acknowledgments

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Dedication

This report is dedicated to My mother, Selinah P. Muvhango, in recognition of your life-long experience and determination to defy inequitable gender norms and practices and for your resolute belief in education. This is for you!

To me, this is the best gift to Myself.

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Acronyms

AIDS: Acquired Immune Deficiency Syndrome

DM: Decision-making

GBV: Gender-Based Violence

HIV: Human Immune Virus

IMAGE: Intervention with Microfinance for AIDS and Gender Equity

IPV: Intimate Partner Violence

NW: North West

PWA: People Living with AIDS

SA: South Africa

SEF: Small Enterprise Foundation

SFL: Sister For Life

SRH: Sexual and Reproductive Health

TS: Transactional Sex

VAW: Violence Against Women

VCT: Voluntary Counselling and Testing

WEE: Women Economic Empowerment

CHAPTER 1: INTRODUCTION

1.1 Introduction

Globally women continue to bear the triple burden of poverty, gender-based violence (GBV) and HIV infections. In South Africa, women remain disproportionally infected with HIV compared to men. The prevalence among adult women and men aged 15-49 was is 25.8% and 15% respectively [1]. In South Africa, IPV accounts for 62.4% of the total interpersonal violence against women [2]. IPV is the most common form of GBV in the country [3] and is also an independent risk factor for HIV infection [3, 4]. Exposure to and fear of violence undermine women's agency particularly in their intimate relationships and this shapes their risk of HIV infections [5].

Studies also indicate that poverty significantly influences the high level of HIV infection among women. More women live in poverty in South Africa compared to their male counterparts (52% vs. 46%) aged 18- 49 years [6]. Poverty plays a crucial role in the lives of women, intersects with women's increased risk of HIV infection and manifests in the form of financial insecurity [7, 8], food insecurity [9, 10], poor education [11] and poor economic conditions [12]. Women also had limited social and economic autonomy which drives their experiences of violence from intimate partners [13, 14]. Poverty also contributes to women's low relationship power and limited agency in sexual decision-making and may influence the exposure of women to risky sexual behaviours such as transactional sex [15].

Women's experiences of poverty and their risk of HIV infection and IPV need to be located in broader social and structural factors that shape the context in which women's sexual behaviour, relationships and HIV transmission take place [13]. This vulnerability among women is underpinned by gender inequalities particularly in relationships [16]. Women's poor socioeconomic status and women being financially dependent on male partners reduce their agency and decision-making power and puts them at increased risk of IPV [14, 17], and HIV infection [18]. The social position of women concerning men is often defined by their gender differences imposed by a patriarchal social system. Patriarchy is simply defined as a set of social structures and practices in which men dominate, oppress and exploit women [19, 20]. Patriarchy functions through a set of social values that endorse male domination and control over women and

the subordination of women to men in a setting where a hierarchy that positions men as superior to women is established. This system informs power relations between women and men in intimate relationships, family relations and society at large, and determines their access to resources, opportunities, expected roles and responsibilities [21]. It is the backdrop against which men develop their ideas about how to behave towards women and other men, and strongly determines women's experiences in their public and private lives.

Gender norms are instrumental in how the system of patriarchy is sustained as women and men are socialized into gender identities of masculinity and femininity, where they are ascribed specific attributes, roles and responsibilities in a particular setting [22]. The work of Connell describes attributes of hegemonic masculinity as a concept that associates successful manhood with being strong, brave and risk-taking [23] while emphasized femininity involves expectations of nurturance, empathy, fragility, and sexual receptivity of women [22]. South African researchers expanded on this concept suggesting that successful manhood not only emphasizes male dominance over women and other men, male sexual entitlement, and sexual prowess but also the use of violence to enforce control over women and other men thus increasing women's risk for HIV infection [16]. While Jewkes and Morrell indicated that the counterpart of successful masculinity in the South African context is acquiescent femininity which is marked by excusing and accepting negative male behaviour [16], ethnographic research expanded on these socially ascribed notions of femininity. The ideal femininity is centred on notions of female dignity, perseverance, respectfulness, obedience, constructiveness and sexual passivity [24].

Scholars perceive male dominance and power underlying notions of masculinity and femininity to be central to women's experience of IPV [16, 25]. Violent men are more likely to engage in antisocial behaviours and to engage in risky sexual practices as one of the ways to demonstrate ideals of masculinity, as a result, they are also found to be more likely infected with HIV [16]. On the other hand, women who are financially dependent or women with low relationship power may be more likely to accept and excuse male partner violence and other negative behaviours such as male multiple partnering and have limited control over their sexual and reproductive health [26].

Interventions to address social, behavioural and structural factors influencing HIV infection, IPV and poor economic conditions of women are critical to ensure women's wellbeing. Unlike biomedical or behavioural approaches to HIV prevention, structural approaches aim to change factors affecting individual risk and vulnerability to HIV behaviour, rather than the behaviour itself [13]. Reviews of evidence show that women's economic autonomy and higher SES reduce their risk of IPV [14, 27]. Addressing autonomy implies tackling the specific gender norms that limit women's economic independence and inequalities that land women in poverty. A few such interventions have been evaluated that address gender norms and economic empowerment of women to reduce their risk of HIV infection and IPV, and these are effective or have the promise of effectiveness in different settings [5, 28-30]. These interventions appeared to work well to reduce factors that increase women's vulnerability, as women reported reduced emotional distress or depression [30], increased income [5, 29, 31], and equitable gender attitudes [28, 31] and reduced controlling behaviour of male partners [31]. These effects need to be understood from a qualitative research perspective to understand how women make meaning of the interventions that have been found to work well in combining gender-transformative approaches with economic empowerment. Exploring participants' experiences is one of the efficient ways to evaluate in order aspects of interventions to determine their relevance and worth.

The IMAGE intervention, a gender-based violence and HIV prevention intervention that combined economic empowerment programme and participatory gender and health training, has been shown through a quantitative evaluation that it was effective in reducing IPV and HIV infection among women and the qualitative assessment also indicated that it was perceived to be accessible and acceptable to participants [32, 33]. However, there is need for an in-depth exploration into participants' experiences and their perceived effects of taking part in the intervention, in order to explore intervention's acceptability to participants and potential effectiveness to inform future programming for more effective and sustainable GBV and HIV prevention.

1.2 Problem statement

Evidence points out that biomedical interventions for HIV prevention have limited effect when implemented in isolation and that structural factors may undermine biomedical and behavioural prevention efforts. Globally, there is growing recognition of the effectiveness of programmes that

combine gender transformation and economic empowerment. Lessons from a few evaluations of HIV and IPV prevention interventions demonstrate that participants usually find interventions to be beneficial others may subject participants to harm such as IPV and psychological distress. Some interventions may be scaled up however without understanding how internal mechanisms and content of interventions may affect participants' lives and their ability to apply learnings into practice.

There is limited research that promotes the inclusion of participant's voices about their experiences and the perceived effects of interventions. Yet experiences and perceived effects from participation in intervention may facilitate or limit future participation or achieving desired intervention outcomes. Quantitative results may also mask the internal workings of aspects of interventions as only a few sets of outcomes may be explored in analysis while other important information about the impact of interventions may point to the extent to which the change seen in the standard two years follow up of evaluations and may not last much longer afterward.

Literature indicates that the experiences of participants from different interventions may vary. Some participants may appreciate the lessons gained from interventions and find it easier to implement the desired change [34-36], however, little is known about those aspects of interventions that are difficult to apply in practice. Understanding participants' experiences, and the perceived effects, of interventions, may go beyond influence acceptability but may go deeper into the question of sustainability. Researchers agree that it is difficult to change gender norms and behaviour hence some propose that interventions should be manualized to ensure standard implementation and messaging with every participant exposed to specific interventions [37]. It is also rare for interventionists to go back to participants to assess the continuous impact of their interventions long after the research evaluations are completed. Assessing the continuous impact of interventions in participants' lives should be standard practice so that interventions remain relevant and have enhanced positive impacts.

1.3 Justification for the study

The study is focusing on the SFL, gender, and HIV training component of the IMAGE intervention and will explore the experiences and effects of participating in the SFL scale up to scale between 2008- 2019.

Though the IMAGE Project was rigorously evaluated from 2001-2005 through a randomised controlled trial and was found to be effective in improving the economic conditions of women, reducing their IPV experiences and HIV risk [5, 38, 39], its accessibility, and acceptability by participants as the project expanded have not been investigated there is no documented feedback from participants about their experiences 10 years since the initiation and evaluation of the overall programme. More specifically, the effects of participating in the gender norms focused of IMAGE, that is, the Sisters For Life component as a standalone programme are unknown and how well the programme is working as an accompaniment of the economic empowerment programme remains unclear.

Understanding participant's voices about their motivations, experiences, and how interventions affect them in real-life settings is critical in assessing programme effectiveness, ensuring user-friendliness of interventions, to inform future improvement, and increase the long term efficacy of the intervention [40]. Understanding the experiences and effects of participating in the SFL gender norms and HIV programme attached to the microfinance programme and delivered by a service-based organization, is a priority if the programme is to maintain its value and remain relevant in participants' lives as well as to ensure that the programme continues to work well in mitigating the structural drivers of HIV and IPV epidemics in the country. Exploring participants' experience and perceived effects of the SFL intervention in their lives enables women's lived experience and participant stories to be explored more in-depth using this approach.

Findings from this evaluation will shed insight into various aspects of SFL and inform necessary or required adaptation for future implementation. Furthermore, globally, it is a critical moment in the field of GBV and HIV prevention were activists, organizations, governments, researchers, and donors are exploring how best to adapt and scale up evidence-based interventions to reach more communities and increase sustainable impact. Therefore, participants' experience from SFL as one

of the proven and scaled-up interventions may provide valuable insight to explore programmatic and operational lessons derived from participants to inform future programming.

This research will generate knowledge about the extent to which the gender norms and HIV training is user-friendly, safe, and relevant and whether its content is on par with other similar programmes accompanying economic empowerment programmes. The data will also help to identify facilitators and barriers to participation as well as potential risks and benefits and inform on areas of strengthening to ensure the programme remains effective over time. Updating the programme is also important as it is being replicated and adapted for different countries. Lessons from this study will help inform any critical adaptations to strengthen the programme and ensure that it remains a viable tool to address inequitable gender norms and prevent IPV HIV.

1.4 Study aims and objectives

1.4.1 Research question

What are the experiences and perceived effects of participating in a gender and HIV programme among women living in the Ngaka Modiri Malema District of Mahikeng Municipality in the North West province of South Africa?

1.4.2 Aim of the study

The study aims to explore the effects of gender norms and HIV training component of the IMAGE programme by exploring participants' experiences and perceived effects among women living in the Ngaka Modiri Malema District of Mahikeng Municipality in the North West province of South Africa.

1.4.3 The objectives of the study

a) To explore participant's experiences of a gender and HIV program among women living in the Ngaka Modiri Malema District of Mahikeng Municipality in the North West province of South Africa.

b) To explore participant's perceived effects of a gender and HIV programme among women living in the Ngaka Modiri Malema District of Mahikeng Municipality in the North West province of South Africa.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter will explore participants' experiences and perceived effects of gender norms intervention that are matched to the economic empowerment programme for IPV and HIV prevention. The chapter will first explore the literature on IPV and HIV prevalence, risk factors, and available intervention for prevention and treatment. It will further focus on the role of structural intervention in IPV and HIV prevention and will more specifically explore the effects of gender norms and HIV training intervention on IPV and HIV prevention as an accompaniment to the economic empowerment programme; from participants' experiences.

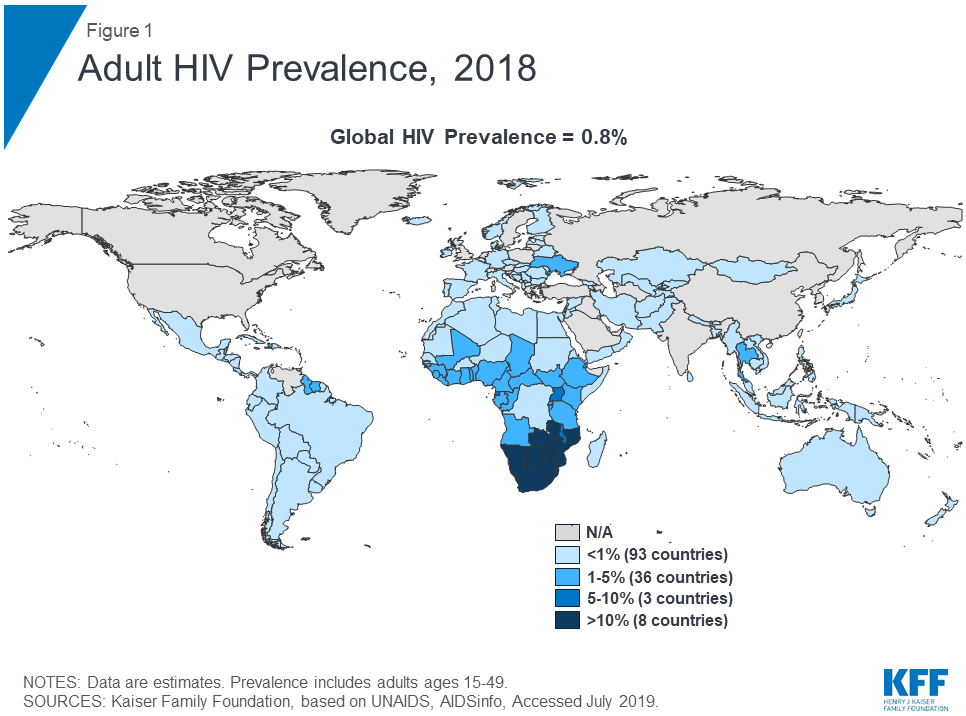
2.2 HIV prevalence

HIV remains a major global health and development challenges. In 2018, approximately 37 900 000 million people were living with HIV/ AIDS globally. About 36.2 million of those infected were adults of 15 – 49 years. Despite the high prevalence, there was a decline in new infections globally, there decline varied depending on the age and sex of certain populations for a specific country [41]. Prevalence among adult women and men aged 15-49 was 25.8% and 15% respectively [1]. About 1 700 000 million people were newly infected with HIV during this period. Young women ages 15-24 are differentially impacted by HIV, accounting for approximately half of new HIV infections and in some areas. AIDS is the leading cause of death among women also associated with pregnancy complications. AIDS-related deaths were recorded at 770 000 at a global level [41].

Sub-Saharan Africa (SSA) remains the region with the highest HIV prevalence in the world as of 2018. SSA accounts for more than half (54%) of the world's HIV prevalence with 20.6 million people living with HIV. The region has witnessed 800 000 new infections during this period, despite high prevalence and new infections, however, the region has recorded a decrease of 28 % of new infections. AIDS-related deaths were at 310 000 [41]. In sub-Saharan Africa, adolescent

girls and young women are at increased risk of HIV infection, young women aged 15-24 constitute a quarter of new infections in the region [41, 42].

Figure 1: Global adult HIV prevalence in 2018 (UNAIDS, 2019)



South Africa hosts the highest number of people living with HIV in the world and is one of the 8 countries in the SSA region with a more than 10% HIV prevalence [41]. Women remain disproportionally infected across all age groups. Approximately 7.7 million people are living with HIV, of which 4.7 million are women, and 2. 8million are men. Prevalence among adult women and men aged 15 -49 was is 25.8% and 15% respectively [1].

2.3 HIV risk factors

In South Africa, the most common mode of HIV transmission is through unprotected sexual intercourse with an infected person [43]. Factors that increase the risk for HIV infection range from biomedical, behavioural, social, and structural. This range of risk factors has translated into the myriad of corresponding interventions to help reduce the risk of HIV infection.

Globally, and in South Africa, women are most at risk of HIV infection and their susceptibility is influenced by biological, behavioural, and structural factors. like violence including physical and sexual violence, gender inequalities, and difficulties in access to services and their biological make-up especially younger women. Gender inequalities, differential access to service, and sexual violence increase women's vulnerability to HIV, and women, especially younger women, are biologically more susceptible to HIV [41].

2.3.1 Biological risk factors

Having unprotected sexual intercourse [44, 45], untreated sexually transmitted infections (STIs) [44-46], as well as the genetics and abnormalities of the vaginal tract that create vulnerability to STIs [47, 48] places women at risk of HIV infection. Engaging in unprotected anal or vaginal sexual intercourse with a person infected with HIV is one of the most common modes of HIV infection [43]. Furthermore, the woman's sexual organs retain semen from the male partner for longer, increasing the chances of HIV infection to women if the partner is infected with HIV [49]. In heterosexual intercourse, a woman is eight times more likely to be infected by HIV than men [50]. Furthermore, the presence of untreated STIs sore on the skin and may cause the skin to break, making it easy for HIV to enter the body [51].

2.3.2 Behavioural risk factors

Some of the behaviours and practices that increase the risk of HIV among women include inconsistent condom use [52-54], having multiple sexual partners [55-57], early sexual debut [58], age-desperate sex [59-61], engaging in transactional sex [15, 62, 63] and alcohol or substance abuse [63, 64]. Ethnographic research indicates that women's vulnerability to HIV infection may sometimes emanate from a combination of both women's risky sexual practices such as multiple partnering and transactional sex, as well as that of their male partners' due to their sexual encounters are less likely to involve condom use [24].

For decades enormous efforts were put into the promotion of correct and consistent condom use but the successes of this campaign are unclear. In a recent South African national HIV prevalence survey an increase in self-reported condom use among women and men aged 25-49 years was observed but the consistency of use remained low [1]. The inconsistencies in condom use and

subsequent susceptibility to HIV infection may be increased by women's inability to negotiate condom use [56] and low relationship power [4, 65].

Research shows that engaging in multiple concurrent sexual partnerships increases the risk of contracting HIV [57]. Multiple partnering is a common practice among women and men however it is widely accepted for men but not women [16, 24]. It also forms part of a set of behavioural attributes associated with successful manhood [16], sustained through beliefs that men have unquenchable sexual appetites and need to have more sexual partners [24, 66-68]. This belief bolsters men's multiple partnering which increases their risk of contracting HIV from unprotected sex and transmitting to other sexual partners. A national household survey reported much higher levels of male multiple partnering compared to female multiple partnering [1].

Furthermore, multiple partnerships among women also form part of a risky sexual practice of engaging in transactional sexual exchange of sex for money or material benefits [56, 69, 70]. Transactional sex is also linked to increased HIV risk among women [69]. In Sub -Saharan Africa, young women aged 15-24 who engage in transactional sex are more than 1.5 times likely to be infected with HIV [71]. HIV infection was 50% higher among women attending antenatal who engaged in transactional sex [15].

Problem alcohol drinking contributes to HIV risk behaviour and thereby increases women's HIV vulnerability particularly sexual activity that occurs in the context of alcohol drinking [63, 72]. Qualitative research shows the nature of HIV risk that women face in their intersections with alcohol drinking and women's sexual relations with men. Accepting alcohol from men in a context of partying implies agreement to have sex and women are prone to unprotected sex, forced sex or rape as they are expected to comply with the sponsoring men's sexual demands [24, 64, 73].

Women's vulnerability to HIV also begins at a younger age [74], and their HIV risk is even higher when young girls engage in sexual partnerships with older men [59]. Among 15–19-year-old young women in South Africa, there is an increase in the age of sexual debut and their engagement in age-disparate sex [1]. The above evidence suggests a clustering of sexual risks that women may be exposed to when they engage with their male partners.

2.3.3 Social and structural factors: gender inequality, gender-based violence and poverty

Gender and economic inequalities inherent in South African society constitute the key social and structural factors influencing women's HIV risk in the country. The World Bank advises that higher gender inequality is associated with higher income inequality and this can be observed in wide gaps in wage and labour force participation between women and men, women being more likely to work in the informal sector where they get lower earnings than men and have unequal access to opportunities, education, health services, and finance [75]. The causes of these inequalities are also deeply rooted in a patriarchal system that promotes male privilege while subjugating women to which members of society are socialized and manifest in the forms of discrimination in roles and responsibilities and access to and control of resources based on gender [76].

Gender and economic inequalities that influence HIV infection emanate from the way people are socialized into certain gender roles and how their social positions are defined. Socialization pertains to the process of internalizing the ideologies, norms and practices of a particular society and encompasses both learning and teaching particular ways of being and relating to others as a means to attain and perpetuate a social and cultural way of life [77]. Several social structures act as agents in the process of socializing individuals and groups and these include family, schools, religion, the workplace, language, media, and in the socio-ecological chain, the state through its constitution, the legal and penal systems, can play the role of enforcing the social ideologies, norms, and practices as social values. Social constructivists also claim that much of human life exists as it does owe to the social and relational influences that contribute to the culture, consciousness, a sense of self, and a sense of community [78], thus supporting the idea that socialization is about learning and reproducing what is learned from socialization agents. This involves promoting a sense of cooperation with others in a society where certain ideologies, norms, and practices are mimicked to demonstrate what has been learned, and a system of rewards and sanctions forms part of ascertaining the extent to which shared social values are reproduced well or not.

Gender refers to the socially constructed ways of being a man or woman [22] and includes the expressions, emotions, thoughts, attitudes, and behaviours that a given culture finds appropriate for specific biological sex [79]. When people are socialized into a particular understanding of gender, they become involved in the process of learning and designing culturally defined gender-related rules, roles, norms, behaviour, expectations, and attitudes that are embedded in the values and ideals of a given society. This process forms the foundation for constructing what it means to be a man (masculinity) or what it means to be a woman (femininity) [22]. There are multiple gender socialization agents which include parents, families, schools, and the community and start at an early age [80]. Human life is thus organized into similarities and differences based on gender and this contributes to imbalances in power relations in many patriarchal societies including South Africa. The gender power theory postulates that gender relations are organized and subordinate women within a patriarchal gender order [22]that is, a historically constructed pattern of power relations between men and women which contributes to the definitions of masculinity and femininity [22]. Gender inequalities are manifested in overlapping social structures of labour, power, and relations that work together in concert to produce social positions of masculinities and femininities [22]. Social institutions such as home, workplace, and school, therefore, contribute to shaping the gendered experiences of women and men [22, 81], entrenching the patriarchal gender order as they support, conform to and perpetuate its ideals, values and practices in ways that permeate to society and evolve [22].

Patriarchy is one of the products of socialization as it is a socially constructed ideology that is perpetuated in many societies in the world. The patriarchal s social system hold men in high esteem and position them in roles of power and dominance, moral authority, social privilege, and control of others particularly women [77, 80]. Sultana also explains patriarchy as a system of society that perpetuates the manifestation and institutionalization of male dominance over women and children in the family, and the extension of male dominance over women in society in general and implies that "men hold power in all the key institutions of society" and that "women are deprived of access to such power" [20]. Others see patriarchy as "a system of social structures and practices in which men dominate, oppress and exploit women" [19]. However, most of the modern societies are patriarchal in their practices even though it is not plainly stated within their constitutions [82, 83]. Patriarchy can also be endorsed and sustained through the perpetuation of commensurate values

in a particular society that usually includes assigning specific gender roles and social expectations associated with socially approved gender identities. For instance, masculinities in the South African context are a set of notions and attributes ascribed to men and include physical strength, bravery, carelessness, dominance, competitiveness [20]. Connell suggests the existence of multiple masculinities in a particular social setting and these present in a hierarchical order [22]. In the context of investigating factors associated with HIV, researchers found that notions of masculinity are shaped through the promotion of male power over women, male sexual entitlement and sexual prowess and these attributes have been linked to women's increased risk of HIV [16]. Studies in South Africa have explained the normalisation of violence and sexual risk-taking can also be linked to notions of dominant masculinity [16, 17]. Male multiple partnering is the most normalized form of sexual risk-taking in South African culture today [24].

In comparison to men, Connell's gender and power theory suggests that unlike in masculinity, femininity does not have a hegemony as it is derived to support the hegemonic masculinity [22]. Emphasized femininity' is thus constructed as an adaptation to male power, privilege and control over women, and other men with non-hegemonic masculinities, and prescribes to women attributes of compliance with male desires and needs [22]. The attributes ascribed include expectations of nurturance, empathy, fragility, and sexual receptivity [22]. Scholarly understanding of femininity has expanded and varied according to social settings similarly with masculinities. While there is limited research on constructions of femininity in South Africa, extensive qualitative research indicates that the dominant notions of femininity emphasize acquiescence which is marked by women's complicity with male dominance and privilege, and women accepting and excusing negative male behaviour [16, 17]. An in-depth study using ethnographic methods has expanded the scope of understanding femininity in South Africa and found that the ideal femininity emphasizes notions of female dignity, perseverance, respectfulness, obedience, constructiveness, and sexual passivity [24]. Marriage is highly valued, perceived as the main arena where women are expected to demonstrate these values and seemingly implies successful womanhood as married women occupy the highest social ranking among other women in the community [24]. Yet this study also shows that femininities observed are constructed in a context of unequal gender relations and power between men and women and further subjugation of women that seeks to undermine women's personal, economic and sexual agency. For instance, women who engage in multiple

partnerships are regarded as *"sefebe*" and are socially stigmatized and degraded as deviant and immoral [24].

Patriarchy is also the underlying factor that informs on how certain social and cultural practices manifest and can be intertwined in the messaging that shape how certain rights of passage such as male initiation and bride grooming before marriage are practiced. For instance, bride grooming is the main arena where social expectations on a young bride are imparted regarding the expected role as a married woman, and this is a reproduction of social expectations previously imparted to her previous generation of mother and aunts and is closely linked with the practice of lobola negotiation. Lobola is the process of negotiation for bride-price for a woman's hand in marriage and involves the exchange of cash and gifts between the bride's and groom's families. Marriage falls within a patrilineal family structure thus lobola negotiations are often led and dominated by the male members of the family and finalized with a symbolic handing over of the bride from her father's authority to her husband's and the affines' authority. So women acquire higher social status [84-86], and are associated with female propriety, security, dignity, and cultural pride [86, 87]. The practice continues despite contestation as objectifying and commoditizing women [87, 88]. The family is the main participant in this cultural practice and is a notable socialization agent of patriarchal values from childhood through to adulthood [89].

Social practices like "lobola" are associated with social expectations that entitle men to control women and condones the use of violence to do so. Gender-based violence (GBV) has been consistently found to be associated with women's increased risk of HIV infection [4, 90-94]. GBV is defined as acts or threats of acts intended to hurt or make women suffer physically, sexually or psychologically [95], and these violent acts or threats occur as a result of the normative role expectations associated with gender, along with the unequal power relationships between genders, within the context of a specific society [96]. GBV constitutes a global human rights and public health concern and its elimination is accounted for under SDG Goals 5 and 16 [97]. Intimate partner violence (IPV) is the most common form of GBV affecting mainly women and girls [98] and measurement includes physical, sexual, economic and emotional abuse by a current or former intimate partner or spouse [99]. Violence against women and girls is mostly perpetrated by male intimate partners or ex-partners [100, 101].

Global statistics indicate that one in three (30%) women will experience sexual or physical intimate partner violence in their lifetime [102-104]. In South Africa, IPV accounts for 62.4% of the total interpersonal violence attributable burden in South African women [2]. Over the past two decades, household survey conducted in some provinces in the country found about 25-40% of women have experienced sexual and/or physical IPV in their lifetime [105, 106], and about 50% have ever experienced emotional or economic abuse by a male partner [106]. Women experiencing sexual violence at an increased risk of HIV infection [65, 90, 107]. There is a need to understand the role of social and structural factors influencing women's HIV risk.

The effects of GBV range from physical, mental or sexual ill-health [108]. Women who have been victimized by intimate partners are reportedly more likely to engage in health-risk behaviours such as alcohol abuse, smoking, and non-medical use of sedatives or analgesics [109]. Some sustain physical injuries, gynaecological disorders, negative pregnancy outcomes, sexually transmitted infections [26, 110], and mental health problems [26], including post-traumatic stress disorder, severe emotional distress and suicidal thoughts [110, 111]. The most extreme consequence of GBV is femicide [112, 113]. Negative effects may also impede women from protecting their sexual health as seen in a systematic review that found women who experienced IPV were less likely to report that their male partners used condoms during sexual intercourse [114].

Poverty and economic inequalities contribute to risk of IPV and consequently HIV infection among women [93]. Gender inequalities associated with sex roles limit women's access to education and latter economic opportunities exposing them to poverty. It further contributes to women's limited personal agency within the relationship and increases their risk of violence. Poverty contributes to conflict within relationships that are associated with the stress of lack of raising children in poverty and the inability to meet basic household needs like food [115].

Women constitute 52% of the South African population. More women live in poverty than men. Adult females experienced higher levels of poverty (52,0%) when compared to their male counterparts (46,1%) across all age groups (18- 49 years) [6]. There is 27.6% unemployment nationally. Having less than a high school education is associated with being unemployed or less

paid work [116] and is ultimately associated with more experiences of poverty. More women are less educated than men. Women with no schooling constituted a high proportion of people living in poverty. An increase in the level of education, especially attaining secondary or post-high school qualification, was associated with a significant decrease in the experience of poverty from 60% - 39% among women thus confirming the importance of education in addressing poverty.

Although men and women experience poverty, women experience poverty differently from men and this is more pronounced when factoring in race, class and other underlying political and cultural conditions. SA's African rural women are on the sharpest edge of poverty. The patriarchal system significantly influences the experience of poverty among women; it marginalizes women and deprives them of equal access to education, paying jobs as well as access to and control of financial resources [21]. Women have limited access to paid work and are usually restricted to lesser-skilled and less-paying jobs like domestic work, clerical positions, waitressing, among others [117].

The International Labour Organization found a high percentage of women in lesser-skilled jobs compared to specialized jobs. For instance, 99% of women are employed as secretaries, 97% child-carers, 95% nurses, 20% physicians, 19% lawyers, and so on. For the skilled jobs, women are paid 28% less than men for the same skills and position. In a report that covered 70 countries, South Africa was found to have the widest wage inequality in the world [118].

Given the women's economic status, women face the burden to meet household needs and childcare particularly when women are heads of households. Female-headed households were almost twice as likely to be poor and food insecure compared to male-headed households [6, 119]. In South Africa, of the 41.3% of households headed by women, 42% were headed by black women and lived in traditional settings. Half of these women lived with extended families [6]. Female-headed households also had less household income and had fewer resources compared to male-headed households (R121 602 and R77 895 per annum respectively). Consistent with their underlying economic conditions black women had the lowest average expenditure [6].

Social grants and participation in social savings groups are critical to address the poverty gap and to improve women's livelihoods and to meet household needs. In the face of widespread poverty and unemployment, women were dependent on remittance, social grans and they further participated in social savings networks [5, 24]. Beyond enabling women to create livelihoods and to save money, social saving networks are sources of support for women including material and emotional support, for instance, showing up and lending a hand during family celebrations or bereavements [24]. Therefore, participation in social networks and savings underscores women's personal and collective agency in improving their economic conditions and which is instrumental in addressing GBV and HIV.

2.4 HIV disclosure, treatment and adherence

2.4.1 The Extent of HIV Disclosure

Despite high levels of HIV prevalence in the Sub-Saharan African region and South Africa, the literature on the extent of HIV disclosure at global and regional national levels is scanty [2]. The available evidence is limited to certain parts of South Africa, and specific populations, and cannot be generalized to the rest of the population. HIV-positive persons face significant challenges to disclosing their HIV serostatus, and failure to disclose can place their sex partners at risk [120]. Evidence suggests that up to one-third of individuals diagnosed with HIV infection continue to have unprotected sex without disclosing their HIV status to their sexual partners who may be negative and that contributes to the spreading of HIV [121].

In a non-randomized study, 92% of respondents self-reported HIV disclosure to other people but 21% reportedly did not disclose to their sex partners [122]. A study of 630 HIV-positive men on ARV therapy reported similar findings: 20% of the participants did not disclose HIV status to their most recent sex partners [123]. In a study of HIV positive pregnant women, 59% reported HIV disclosure to their male partners.

HIV disclosure is a gateway to HIV treatment, care and support services. Disclosing HIV status is considered a criterion for access to HIV treatment, care and support services including membership in support groups for people living with HIV and ensures adherence to treatment [124]. However,

there is conflicting evidence of associations between disclosure and access to HIV treatment, care and support services. Vu and colleagues claim that access to ARVs facilitates HIV disclosure [123] whereas other scholars found being on ART does not guarantee HIV disclosure and access to HIV counselling, treatment or support services [122].

HIV disclosure is also believed to potentially enable people to adopt HIV preventative behaviours [125]. Disclosure of positive HIV status was associated with condom use also among serodiscordant partners [126], improved access to prophylaxis treatment to preventative transmission to other sexual partners [127], and HIV testing [126]. On the contrary, however, being aware of a partner's positive HIV status or disclosing one's HIV status to a partner was not associated with safer sex behavioural practices among adolescents [128]. Previous studies indicated that non-disclosure of HIV status to sexual partners contributes to risky sexual behaviours and increases the risk of sexual HIV transmission [129]. Another study found that people who have not disclosed their status to sex partners are more likely to have multiple partners, HIV-negative partners, and unprotected intercourse with non-concordant sexual partners [124].

Besides, non-HIV disclosure is further associated with poor adherence to HIV treatment. In a study of ART adherence, 19% of HIV-positive patients reported having missed taking their medication due to concerns they would be exposing their HIV status to others including friends, family, and intimate partners [130].

2.4.2 Barriers and Facilitators of HIV Disclosure

HIV stigma and discrimination are the major barriers to disclosure and prevent access to HIV testing, treatment, care and support [2, 123, 124]. Fear of stigma [131, 132], discrimination [133], beliefs and knowledge about HIV [132] have been associated with non-disclosure of HIV status. A study of 438 HIV positive women attending antenatal clinics in South Africa also found that HIV stigma and the inability to cope decreased the likelihood of disclosing HIV status to others after disclosing to a male partner People living with HIV also attribute non-disclosure of HIV positive status to their fear of job loss, not having a place to stay and being accused of infidelity [124]. Fear of blame, abuse [124, 134] and abandonment [124, 131, 133, 134] also reduced willingness to disclose HIV status to intimate partners.

There is a strong association between HIV infection and women's experiences of IPV. Experiencing IPV increases the risk of incident HIV infection among women [93] and men who perpetrate violence are more likely to be HIV positive and this further increases the chances of female partners contracting HIV [92]. This association between incident HIV infection and IPV points to the gender inequalities between women and men in relationships [4]. Relationship conflict is associated with intimate partner violence and increases communication difficulties [135]. HIV disclosure influences relationship conflict emanating from arguments and blame for 'bringing' HIV into the relationship when one discloses positive HIV status to a male partner [136, 137]. Qualitative research among HIV positive pregnant women in three antenatal clinics confirms the bidirectional relationship between IPV and HIV as authors found that IPV also led to secondary HIV risk as women reported forced sex attributable to limited power to negotiate condom use or ensure their safety during pregnancy [138].

Scholars found no significant gender differences in levels of HIV status disclosure between men and women. However, there was gender variation in motivations and barriers to disclosure. Factors that facilitate HIV disclosure include perceived support from family, and perceived benefits of disclosure and whether they are married or casual partners, knowledge of or partner's known HIV status, the perception that they will experience less stigma and discrimination, and if they are more educated were predictors of HIV status disclosure [123].

Factors that facilitate HIV disclosure include perceived support from family, and perceived benefits of disclosure, sex of an individual whether male or female and whether they are married or casual partners, knowledge or partner's known HIV status, the perception that they will experience less stigma and discrimination and if they are more educated. Partners were more likely to disclose if they perceive that they will get support from family, friends or partners [2, 127]. Family members and partners are reportedly the main sources of moral support following HIV diagnoses and also contribute towards improved adherence to HIV treatment [122, 139]. Access to health care also positively influences HIV disclosure [2, 127].

A study that examines factors influencing disclosure of HIV status to sexual partner found that individuals are more likely to disclose HIV status to a steady partner than a casual partner, and women were more likely to disclose compared to men and more specifically those in heterosexual relationships [123]. A review of studies on male self-disclosure of HIV status to sexual partners found that HIV disclosure decreased by the number of sexual partners men had and self-disclosure was not consistently associated with safer sex practices [140]. Other research suggests that people are more likely to disclose positive HIV status if they know their partners' HIV status [141]. Knowing someone who is living with HIV also reduces HIV stigma and risky sexual behaviour [2, 142]. There is also research suggesting that disclosing HIV status gives a sense of freedom from the psychological and emotional burden associated with hiding HIV status and that could add to personal empowerment [141].

Sociodemographic factors are also believed to influence HIV disclosure. For instance, education is also reported to increase the likelihood of HIV disclosure [143] while and feeling one can maintain livelihoods after disclosing their HIV status is also positively associated with doing so [2, 127]. Research among HIV positive pregnant women in South Africa also highlights social, demographic and psychological factors that affect HIV disclosure to male partners. A study of 438 HIV positive women attending antenatal clinics in South Africa showed that being married, previously discussing HIV testing, the partner's higher educational status and lower experience of violence facilitated disclosure of HIV status to male partners. Better housing, less financial dependence on male partners and knowing someone with HIV were also associated with disclosing to others [144].

2.4.3 The Extent of HIV treatment

Access to a combination of effective HIV prevention, testing, treatment and care services is critical to optimal management of HIV infection and HIV testing is the gateway to access treatment [145]. Although HIV remains a major public health challenge, access to Antiretroviral Therapy (ART) has made HIV/AIDS a manageable condition and has enabled people living with HIV to lead long healthy lives [41].

The function of Antiretroviral therapy is to suppress viral replication and strengthen the immune system to enable it to fight infections hence ART involves treatment for opportunistic infections. ARVs are also used as a preventative strategy particularly among serodiscordant couples as the medication lowers the risk of HIV transmission [146], and this is supported by evidence suggesting that getting more people on ART was associated with a reduction in the number of new HIV infection. Studies claim that an ART coverage of 30-40% contributes to up to 38% reduction in new HIV infection in a population [146]. World Health Organization recommends that all people living with HIV including children, adolescents and adults, and pregnant and breastfeeding women, should be given ARVs regardless of clinical status or CD4 cell count [147] and that that ART has significantly reduced morbidity and mortality rates [147]. Research in South Africa concurs as mathematical modelling of study of mortality rates found that during the 2000–2014 period, the cumulative number of HIV deaths in adults was significantly reduced and life years were saved in adults due to enrolment on the ART programme [148].

In 2015, the United Nations General Assembly committed to the Sustainable Development Goals (SDGs) and Goal 3 seeks to ensure good health and wellbeing for people. Among the priorities within this goal is to end HIV/AIDS by 2030. Earlier, the Joint United Nations Programme on HIV and AIDS (UNAIDS) also set the "90-90-90" target that aims to achieve 90% of people knowing their HIV status, 90% of HIV positive people on ART, and 90% of those on treatment virally suppressed by 2030 [149]. The global coverage of these 90-90-90 targets in 2018 was 79% of people living with HIV were tested, 78% of them were on treatment, and 86% had suppressed viral load [41]. South Africa is among the countries reportedly making progress to achieve the UNAIDS 90-90-90 targets: 90% (7 004 000) of people were HIV tested and 62% (4 788 000) of those tested were on ARVs and 54% (4 172 000) achieved viral suppression by the end of 2018 [41]. Consistent with the disproportionate HIV infection among women, 65.5% of women are on ART compared to 56.3% of men [1]. However, there is significant room for improvement as approximately 2.9 million people living with HIV are not getting the treatment they need.

South Africa has been hailed for its success in improving access to treatment among children and adolescents. A study of adolescents being treated for HIV in SA revealed a 10-times increase in the number of adolescents receiving ARV treatment between 2010–2018 [150] although access to

treatment for adolescent girls and young women can be limited. 45% of girls and 42% of boys aged 15-19years initiated ARVs compared to 68% of girls and 69% of boys aged one to four years. The factors inhibiting young people from seeking ARV treatment include the stigma associated with living with HIV as a young person, perceived lack of confidentiality at health facilities, the need for frequent visits to clinics to start and maintain treatment and increasing responsibilities at home [151]. Vu and colleagues had indicated that having access to and using ARVs also contributes to HIV disclosure and this improves the quality of life [123]. A systematic review of thirteen cross-sectional studies among HIV-positive women also recorded IPV as a key factor limiting women's use of ARV treatment [136].

2.4.4 Adherence to HIV treatment

Adherence to ART treatment is critical to ensure the medication to arrest the virus causing AIDS. With proper adherence, the virus can be suppressed to undetectable levels and reduce the chances of transmission to another person. Hence researchers claim that adherence to ART is a strong predictor of viral load suppression, immune recovery, disease progression, and death from opportunistic infections [152]. However, the rates of adherence are not optimal. A study of 735 HIV-positive patients found that 70.8- 82.9% were adherent [153] and another study showed that with a long-term structured ART programme and close adherence monitoring, rates of adherence can be improved up to 94-96% [154].

A range of factors that influence individuals' adherence to ART. Discrimination experiences, use of herbal medicines for HIV, traditional beliefs about HIV and AIDS, and lack of social support were associated with lower adherence [153, 155]. Higher adherence information, behavioural skills, higher social support, were associated with higher adherence [153, 155]. Placing a higher value on the treatment and one's life, and maintaining a daily routine also influenced adherence [155]. Other factors that improve adherence are perceptions of good health after commencing ART, lower depression [156], and fewer opportunistic infection symptoms [157], and having the appropriate health care facilities and counselling services [158]. Orrell and colleagues found that health workers speaking the same language as the patient's site staff and providing them with a simplified dosing frequency helped with adherence [152]. Social and demographic factors related

to food insecurity, living in urban areas, lack of transport infrastructure, and income also influenced the ability to be adherent to ART [158].

There are inconsistencies in findings of levels of adherence by gender with some studies finding low adherence rates among both men (48%) and (51%) women [159]. Whereas a review of literature on treatment adherence by gender found women to be less adherent compared to men [160]. The common contributing factors to women's lower levels of adherence include lack of supportive interpersonal relationships, depression, being young and substance abuse [160]. Furthermore, relational factors such as gender inequalities also contribute negatively to adherence to ART [158]. This is consistent with studies that found that HIV-positive women who are experiencing IPV have a halved likelihood of adhering to HIV treatment [136]. IPV also worsens women's adherence to mother-to-child prevention of HIV as taking treatment or accessing health services may inadvertently alert male partners of the women's HIV status [138].

2.5 HIV and GBV prevention programmes

With millions of people living with HIV worldwide, the numbers increasing each year and a vaccine yet to be discovered, the prevention of new HIV infections remains an urgent priority [161]. There are diverse types of interventions to prevent HIV transmission through a combination of complementary programmes that employ biomedical, behavioural and structural strategies, and these have different levels of effectiveness. These HIV prevention programs are implemented to address HIV at different levels of the ecosystem: at the individual, relationship, community, and societal levels.

2.5.1 Biomedical interventions

Biomedical interventions use a mix of clinical and medical approaches to reduce HIV transmission including screening and treatment of STIs, HIV testing, male circumcision, condom use, microbicides, Antiretrovirals Treatment, and, Pre-Exposure Prophylaxis (Pr-EP). Condoms have been proven to prevent infection from HIV and other STIs by up to 85% when used correctly and consistently during vaginal and anal penetration [41]. While consistency in condom use is critical for its effectiveness in preventing transmission, however, there have been challenges to achieve this [162, 163]. The socio-economic conditions and gender inequalities continue to limit women's

ability to negotiate condom use [16, 56] or their sexuality in general due to how gender inequality diminishes their agency in relationships [16, 164]. This called for the need to develop female-controlled approaches such as microbicides and ART or Pre-exposure prophylaxis. Several trials studying the use of oral and topical agents for the prevention of HIV infection have found these types of interventions have limited effect and are confronted with side effects and issues of adherence that prove challenging to achieve efficacy [161].

Medical male circumcision is one of the promising bio-medical interventions found to reduce the risk of heterosexually acquired HIV infection in men by 46-61% in South Africa [1, 165]. However, little is known about these positive effects that translate into reduced HIV risk among women.

HIV testing of intimate partners of HIV positive people is seen as an entry point to HIV prevention and treatment services. The WHO recommends assisted HIV partner notification services as a simple and effective way to reach the intimate partners many of whom may go undiagnosed as they may be unaware of their HIV exposure. This initiative assumes they may welcome support and an opportunity to test for HIV [166]. Testing for HIV status is assumed to contribute to safer sexual practices and knowing one's status enables individuals to either seek preventative or treatment services. Couple counselling and testing for HIV and HIV disclosure are among the more elaborate services recommended ([41]. There is also strong evidence from observational studies indicating that the acquisition and transmission of HIV infection are enhanced in the presence of other STIs and this led to recommendations that improved STI screening, testing and treatment should form part of HIV prevention and control programmes [167]. Of the HIV infected people in South Africa, 75.2 % had been ever tested for HIV but women are more likely to have tested for HIV compared to men [1]. Couple testing facilitates simultaneous HIV disclosure and contributes to a significant decline in unprotected sex observed in some studies [168].

Treatment as prevention (TasP) refers to taking HIV medication to prevent the sexual transmission of HIV. Using antiretroviral therapy (ART) can arrest HIV progression and reduce mortality, and early initiation of therapy may provide individual and public health benefits compared to deferring treatment [169-171]. For women, the use of ARVs has been applied in microbicidal interventions,

prevention of transmission during the sexual assault, and the prevention of mother-to-child transmission with different degrees of efficacy [172, 173]. However, despite these biomedical interventions, there is a need to address the behaviours that contribute to the further spread of HIV infection.

2.5.2 Behavioural interventions

HIV prevention interventions also seek to reduce the risk of HIV transmission by addressing risky sexual behaviours that have been developed and some evaluated in South Africa. Risk reduction programmes often focus on changing behaviour by promoting condom use, and the reduction of the number of concurrent sexual partners and substance abuse [174-176]. Some of these programmes are combined with aspects of STI and HIV testing and treatment promotion, inequitable gender norms, and IPV [121, 177-179].

2.5.3 Structural interventions

Bio-medical and behavioural interventions to prevent HIV have been of limited effect when implemented in isolation [180, 181], thus highlighting the need to address underlying structural factors that continue to undermine prevention efforts including the physical, social, cultural, economic and environmental factors that shape the context in which HIV transmission occurs [182, 183].

Structural interventions seek to change the environment in which people act, to influence their health behaviour. For instance, interventions that address gender inequalities and IPV attempt to tackle the experiences, assumptions and positions that undermine women's ability to negotiate condom use, exacerbate their vulnerability to HIV or prevent their access to HIV services [184].

South Africa has locally developed and tested several targeted interventions that ultimately influence HIV transmission. Some interventions seek to prevent violence before it happens by targeting children and their parents [185], and such interventions are seen as mitigating HIV risk attributed to IPV perpetration or victimization linked to childhood exposure to violence [186]. Some school-based programmes seek to prevent IPV among teenagers [187].

A gender transformative programme that aims to prevent HIV by changing gender norms and risky sexual behaviour [178] also found that about 13.9% of new HIV cases among women could be avoided by enhancing gender equity in heterosexual relationships and 11.9% of HIV infections could be reduced by preventing women's exposure to IPV [4]. This intervention was further combined with a livelihood strengthening component thus recognizing that improving women's economy has the potential to prevent their exposure to IPV and HIV infection. These programmes show promise in their ability to achieve this[30, 31] and demonstrate the need for qualitative research to understand how to enhance effects of structural programmes in improving impact in women's lives.

The IMAGE project is one of the first structural interventions for HIV prevention to be evaluated in South Africa. It combined economic empowerment-centred group-based microfinance components with a 12-month gender and HIV training curriculum that targets women to reduce poverty, gender inequalities, intimate-partner violence and HIV infections [5]. The evaluation showed a 55% reduction in the risk of IPV and improved women's economic well-being including household expenditure and assets as well as improved self-confidence, autonomy in decision-making, challenging gender norms and women living abusive relationships [188, 189]. A follow-up evaluation to assess the relative benefits of the IMAGE project, that is microfinance and gender and HIV training) compared to a standalone microfinance component found that while microfinance produced economic benefits on its own, it was only the combined IMAGE model which facilitated more gains in reductions in the risk of HIV and IPV, women's empowerment, social well-being and health [190]. Exploring this differential impact from participants' perspectives is important for the continuous improvement of such evidence programmes in the public health field.

Further research indicated that participants' motivation for enrolling on the intervention was to join a new social network which was perceived to improve self-esteem and confidence and enhanced participation in other social networks within their communities [39]. The advice, material, financial support also motivated participation [33] as trust and solidarity among participants were seen to be critical in shaping how individuals experienced the programme [32, 39]. However,

participation was often limited by several factors. Women over the age of 35 years were less likely to attend the IMAGE project and some of the reasons given for poor attendance included being uncomfortable to discuss topics regarded as taboo especially when facilitated by young trainers. On the other hand, such concerns subsided over time as participants started to realize IMAGE project's relevance to their lived experiences. Other women cited being constrained by male partners, sicknesses, childcare, and having other business responsibilities. Some participants were reluctant to participate as they were only interested in the economic component; they found the heath component irrelevant as they were interested in the loans, while others were not aware that participation in the gender and health training is compulsory when they take a loan [33]. Few participants who dropped out of the programme mentioned challenges in making loan repayments as the main reason and even fewer dropped out as a result of the heath component [5, 32].

Another qualitative assessment to understand pathways for a significant reduction in risk of violence explored participants perceived changes occurring within intimate relationships, loan groups, and the community and found a range of responses contributed to a reduction in risk of violence and those included women being enabled to challenge the acceptability of violence, expecting to and receiving better treatment from partners, leaving abusive relationships, and raising public awareness about intimate partner violence [38]. Participants also perceived that the IMAGE intervention shed new insights and enabled them to open up and share new information with family members [39, 191] and being elected into a leadership positions were perceived to have improved their self-confidence [5, 32] [33]. However, we don't know how well SFL contributed to the overall IMAGE project success and want to know by investigating how participants felt about participating it and what they think they got from it.

2.6 Participation in HIV and GBV interventions

There is a need in South Africa for programmes that combine economic empowerment and gender norms change to prevent IPV and HIV to understand how each component contributes to the overall impact of combined interventions. Commonly, parts of interventions are developed as separate components first before they are combined as a package. This study seeks to explore the potential contribution of gender norms and HIV programme matched to an economic empowerment programme, to explore its efficacy in improving gender-equitable ideas, promoting

HIV prevention, treatment, and care, and supporting the economic empowerment of women. Doing so is important as existing programmes that seek gender norms change have been evaluated and their merit as gender transformative programmes proven. The evidence of the effectiveness of the Stepping Stones programme as a gender-transformative and effective in preventing HIV risk factors was demonstrated first [192] before it enhanced with livelihoods strengthening component, Creating Futures, and found work well in reducing IPV perpetration and improving livelihoods of both women and men [30, 31].

Participant's experiences of interventions are critical to inform how different aspects of the intervention contribute to its effectiveness, from design, target group, accessibility, feasibility, delivery, impact, sustainability, and scalability. Moreover, understanding participants' experience of interventions also sheds light on the ethical considerations of providing interventions for public health problems. Some studies have explored participants' motivations and their perceived risks and benefits of participation while others sought to understand facilitating and inhibiting factors to participation [193, 194]. Such studies provide information on how interventions affect and influence participants' lives and enhance the interpretation of intervention outcomes whether interventions are effective or not. While participants are motivated to participate in interventions, they also come across desired and undesired effects during and following their participation. Their experiences also have implications on the programme delivery and its ability to achieve desired outcomes. Typically, participants are motivated to attend interventions to access information and acquire skills to prevent public health problems such as HIV or GBV while others' motives altruistic in nature [35, 193, 194].

However, participation in intervention may not always have the intended outcomes. A study of women's experiences of intervention for violent men found that while the male participants claimed they had not been abusive towards their female partners, interviews with their female partners provided contradicting evidence [40]. This highlighted the potential harm some interventions may have and implied that some self-reported behaviour change may not be genuine or may reflect social desirability bias. Some participants tend to regret taking part in interventions and such regrets differ and affect more women than men who attend programmes. This may reveal

critical information about the safety and risks that women face during or after participating in HIV and GBV prevention interventions [194].

Combined interventions are often complex and lengthy. The feasibility and accessibility and acceptability of the delivery model may be uncertain, and this may also impact participation. Understanding participants' experiences and their perceived effectiveness of interventions may assist in intervention strengthening and mitigating aspects of such lengthy programmes. Such information may provide insights that can inform future programming.

CHAPTER 3: METHODOLOGY

3.1 Introduction

The chapter describes the research process applied in undertaking this study, including the study design, scope, setting, population and sampling, data collection and analysis process. It also presents limitations and ethical considerations, as well as how the findings will be disseminated and utilized.

3.2 Scope of the study

This study aimed to follow up with women who participated in the Sisters for Life (SFL) programme to explore their experiences and the perceived effects of their participation. Specific goals included obtaining women's accounts of how they felt about participating - considering it used both male and female facilitators - as well as learning what the programme provided, what it meant to them and their experiences with the programme's delivery method. The study also wanted to understand participants' knowledge of gender norms and attitudes, relationships, and health matters (including HIV). It further wanted to explore the perceived effects of the SFL programme on the information and ideas retained and practiced by participants, and whether the programme had changed their attitudes and behaviour in any way.

3.3 The Intervention

The intervention under research in this study is the SFL gender and HIV training programme, a component of the Microfinance for AIDS and Gender Equity (IMAGE) project. The IMAGE project aims to improve the economic well-being and independence of communities, reduce vulnerability to both HIV and GBV, and foster robust community mobilization to address common concerns. Based in rural South Africa, the IMAGE project combines group-based microfinance with a 12-months gender and HIV curriculum called Sisters For Life.

The combined intervention is organized into two parts: The microfinance component is based on the Grameen model and is offered by The Small Enterprise Foundation (SEF). This provides loans to low-income rural women for income-generating purposes. A group of five women guarantees

each other's loans, with loan centres of approximately 40 women meeting fortnightly to repay loans, apply for additional credit, discuss business plans, and receive mentorship on business skills development. This microfinance component facilitates social and economic well-being and provides a client base and platform for SFL delivery.

The IMAGE project is an NGO. It delivers the SFL training alongside the microfinance services using a separate and specially trained team of women and men facilitators aged 30 to 45 years. Based in Johannesburg, its satellite office is based in Mahikeng, North West (NW) province. It consists of 12 Community Training Facilitators (CTF) (eight female and four male) and two female Training Supervisors (TS). Male facilitators are included in the CTFs to facilitate engagement with youth and men in the community. Six CTFs and one TS were allocated to the Mahikeng satellite office. Facilitators had post-matric qualifications in the field of social sciences, health studies or a post-matric certificate in the field of HIV, as well as a minimum of two years' working experience as a training facilitator before they could be appointed as trainers. Fluency in local (Setswana or Sesotho) languages and familiarity with the local culture of the ethnic group and traditions was a key requirement.

Once appointed, facilitators spend a minimum of four to six months in training: one-month in-classroom training and three months of field practice and evaluation of the quality of their training and facilitation skills. The training focuses on gender, domestic violence and HIV, personal reflection and development, information, and technical skills like facilitation skills. They are further trained on the SFL curriculum, initially as participants and then as facilitators.

One SFL facilitator is responsible for eight to twelve loan centres with an average of 40 women in each loan centre. So, one facilitator is responsible for a minimum of 320 to 480 participants. They run two sessions per month in each centre making a total of 16 – 24 sessions in a month.

The SFL programme consists of two phases: Phase 1 includes a series of 10 one-hour sessions on topics such as gender roles, cultural beliefs, power relations, sexuality, self-esteem, domestic violence, and HIV (Table 1). Participatory methods are used to increase participants' confidence,

particularly around communication skills, and encourage critical thinking on the links between culture, GBV, and HIV.

Table 1. Sisters for Life Phase 1 training curriculum [195]

SESSIONS	GOALS	ACTIVITIES
Session 1: Introductions	• Help participants and facilitators get to know one another and feel comfortable • Provide an overview of programme	• Introduction • Overall goals and programme • Expectations and concerns • Ground rules
Session 2: Reflecting on culture	• Consider traditional wedding songs, names, and proverbs about women, and explore their content and meaning • Understand how gender roles and conditioning are reinforced from an early age	• Wedding songs, names, and proverbs • Girls do's and don'ts
Session 3: Gender roles	• Consider the differential workloads and responsibilities of women and men • Analyse how much of women's time is devoted to others and how much to themselves	• 24 hours in a woman's day: map out hourly activities for a typical day
Session 4: Women's work	• Explore the implications of women's heavy workloads on their health and well-being • Understand the difference between 'sex' and 'gender' • Explore and challenge the notion of 'culture' and how it reinforces gender roles and stereotypes	• Continued group discussions: 24 hours in a woman's day
Session 5: Our bodies, ourselves	• Become more comfortable speaking about the body, sexuality and women's feelings concerning these • Explore women's understandings of their bodies, particularly concerning menstruation and sexual intercourse	• Group discussion: defining 'womanhood' and what it means to be a woman • Body mapping: menstruation, sexual intercourse
Session 6: Domestic violence	• Explore a range of experiences constituting domestic violence	• Group discussion: forms of violence experienced or

	• Explore attitudes, beliefs, and experiences related to domestic violence • Understand how it is perpetuated, and link this to prior sessions on gender roles and culture	witnessed • Roleplay: mother-in-law speaking to a daughter-in-law who has been beaten by her husband
Session 7: Gender and HIV	• Cover basic information on HIV/AIDS, including prevention, transmission, and myths • Explore the reasons why women (especially young women) are at high risk • Link social context of women's risk to previous sessions on gender roles, culture, and domestic violence	• Group discussion: HIV basic information • Trends and statistics: women and HIV • Who is at risk? Discussion of two stories
Session 8: Knowledge is power	• Introduce voluntary counselling and testing (VCT) and where it is available • Prepare women to think about VCT, reasons for testing, and fears and concerns • Bring home the reality of HIV by speaking to a person from People Living With AIDS (PLWA).	• VCT demonstration • Visualization exercise: finding out the HIV status of yourself or someone you love • Disclosure session: PLWA tells her story
Session 9: Empowering change	• Explore why negotiating safer sex with a partner is difficult • Explore why speaking to youth about sex and HIV is difficult • Practise communication skills and exchange strategies and personal experiences	• Roleplay 1: Speaking to your partner about safer sex • Roleplay 2: Speaking to a young person about sex
Session 10: Way forward	• Summarise and link all previous sessions • Explore obstacles and opportunities for greater involvement of youth and men • Link Phase 1 to upcoming leadership training and Phase 2	• Review of previous sessions and appreciation of progress • Group discussions: what can we change? What can't we change? • Next steps and closure

Phase 2 encourages wider community mobilization to engage both youth and men in the intervention villages and sensitize them about issues of GBV and HIV with support from facilitators. Women deemed 'natural leaders' by their peers are elected by loan centres to undertake a further week of training on leadership skills and community mobilization. The selection of

Natural leaders marks the beginning of Phase Two. After this, they work with their loan centres over six months to develop 'village-level action plans' that address a range of challenges, including priority issues such as HIV and GBV [176].

3.4 Study design

This research is a descriptive, in-depth, qualitative exploratory study. Qualitative research enables an in-depth understanding and advanced knowledge when little is known about the phenomenon [196, 197]. Consistent with the study's aim, this form of research recognizes that study participants possess the best knowledge about certain phenomena based on their experience, and the meanings they attribute to that experience are of the utmost importance. Qualitative research can capture the meaning underlying participants' descriptions of their experiences, attitudes, and behaviours [198].

3.5 Study setting

The study was conducted in the Ngaka Modiri Malema district within the Mahikeng Local Municipality of the North West Province in South Africa. North West is South Africa's third-smallest province with a population of 3.9 million in 2019, constituting 6.8% of the population [6]. About 97% of the population identifies as black African, 2% as coloured, 1% as Asian/Indian, and 1% as white. The vast majority of Mahikeng's population lives in rural areas (83%) and a significant number are female households (44%). SeTswana is the language most spoken at home (85%), compared to SeSotho, isiXhosa, and Afrikaans [199]. HIV prevalence in the NW Province was estimated at 14.5% compared to 14.0% for the country [1].

North West has six towns: Mahikeng (the capital), Rustenburg, Brits, Klerksdorp, Ventersdorp, and Vryburg. It has modern infrastructure that includes schools, hospitals, and clinics, as well as main roads connecting the province's major towns to the rest of the country. Additionally, the main railway line from Cape Town to Zimbabwe runs through Mahikeng, linking the North West province to Angola, Zambia, and Botswana. The province also has two airports, Mahikeng International Airport and Pilanesberg International Airport.

Mining is the dominant sector contributing 32.5% in the province's economy and 23.9% to the national economy. NW is the largest platinum producer contributing 50% of the world's platinum; 64% of the platinum produced in SA comes from NW. Its unemployment rate of 26.4% as of March 2019, is marginally lower than the national level of 27.6% [6]. Since Mahikeng is the provincial capital and home of the legislature, the government is the main employer and accounted for 35.4% of employment in 2017 [200]. A total of 32% percent of Mahikeng's population was employed and had an average annual income of R30,000 [199].

Mahikeng, the provincial capital and study site, features a mix of indigenous African settlements and western-type development. Its long political history includes being governed by the Barolong tribal leadership before being under siege during the 1899-1902 Anglo-Boer War. It served as a British colonial capital of the Bechuanaland Protectorate from 1894 until 1965 even though it was situated in South Africa. When Botswana gained independence from Britain in 1966, Gaborone became its new capital and Mahikeng lost its capital status. In 1977, the apartheid government created the Bantustan[1] Bophuthatswana. Mafikeng regained its political status as a capital in 1980, this time as the capital of Bophuthatswana. Post-1994 it became the capital of the newly-formed North West Province [200]. The transitions in governance resulted in fluctuations in its economic status.

3.6 Study Population

The sample was drawn from 2,299 women aged 18 to 70 years who were enrolled members at 77 loan centres for periods ranging from a minimum of six months to three years. Centres were located in 50 rural villages around Mahikeng.

3.6.1 Inclusion criteria

Participants were included in the study if they: a) had participated in the SFL programme during the delivery of SFL sessions from 1 February to 31 December 2016, b) had participated in one or more of the 10 SFL sessions, c) were aged 18 to 50 years, and d) were willing to participate in the study. Participants were excluded if they did not meet the inclusion criteria.

[1] A partially self-governed area created during apartheid for a particular indigenous African group—a so-called 'homeland'.

3.6.2 Sampling strategy

Purposive sampling was applied to select the study sample. Unlike other probability sampling techniques striving for representativeness or generalisability, purposive sampling strives for credibility [196, 197]. It remains relevant in qualitative research, as the researcher deliberately chooses participants perceived to possess rich, credible knowledge or experience relevant to the study objectives; this method improves the validity of the study findings [201].

A cross-sectional approach was used in the selection of the study sample. The researcher selected participants from the overall pool of SFL programme participants that were scheduled to attend monthly loan centre meetings from 20 to 31 March 2017. The researcher used existing SFL attendance records and loan centre meeting schedules to identify clients meeting the inclusion criteria to draw the sample. The SFL training attendance records contained details on 2,299 women who were enrolled to attend SFL training during the delivery of SFL sessions from 1 February to 31 December 2016, the period under investigation. The attendance records detailed the name, age, a period of participation, the number of sessions attended, loan centres they belonged to, and corresponding villages.

To maximize variation in the sample and to increase comparability of findings related to participant experiences and the effects of SFL participation, participants were matched based on age and level of SFL completion. 'Level of SFL completion' refers to whether participants attended all or some of SFL Phase 1 sessions. Only participants who attended all 10 of SFL Phase 1 sessions were considered to have completed SFL. Those who attended less than 10 of SFL Phase 1 sessions, regardless of how many sessions they missed, were considered to have not completed SFL. Those who completed SFL were matched with those who did not complete SFL. They were categorized according to six age groups: 18–25, 26–30, 31–35, 36–40, 41–45, and 46–50 years old.

3.6.3 Sample

The final study sample included 17 women from the six loan centres. Seven women had completed the SFL programme and 10 women had not completed the sessions delivered in 2016. The two categories were pair-matched by age (Table 2).

Table 2. Sample selection

Age group	Participants who completed SFL / attended all 10 SFL sessions (age)	Participants who did not complete SFL/ attended less than 10 SFL sessions (age)	Total sample per age group
18–25	1 (25)	1 (25)	**2**
26–30	1 (29)	1 (29)	**2**
31–35	1 (34)	1 (32)	**2**
36–40	2 (38, 40)	1 (38)	**3**
41–45	1 (45)	3 (44 [one participant] and 45 [two participants])	**4**
46–50	2 (50)	2 (46, 47)	**4**
Total	**7**	**10**	**17**

3.6.4 Participant recruitment

The researcher was granted permission to conduct the study and to visit loan centre meetings by the founder and head of IMAGE.

The researcher used electronic SFL attendance registers to identify and enlist participants who met the inclusion criteria and to ascertain the names of loan centres to which they belonged. She accessed the loan centre schedules to identify villages where the loan centres were located and scheduled dates and times for loan centre meetings to interview participants.

The IMAGE project staffs who were working in loan centres were also informed about the study and were requested to inform women at centre meetings. The researcher communicated with the operational manager who oversees field staff who was requested to inform staff about the researcher's intention to visit centre meetings.

With guidance from the IMAGE staff leading the groups, the researcher visited loan centre meetings where selected participants were scheduled to be present at loan centre meetings. On arrival, the IMAGE staff officer introduced the researcher to the group leadership committee of the loan centre and explained the purpose of the visit. At the beginning of the loan centre meeting, the loan centre leadership introduced the researcher to members of the groups. The researcher was

allowed to explain the study and provide all the details including the participant selection process and the data collection procedure. Thereafter, the researcher notified the selected individuals and met them individually. Using the participant information sheet (Appendix B), the researcher explained the study, its purpose, procedures, how data would be analysed, anonymization of data. She allowed each of them to ask questions and clarified their questions. She sought their informed consent to participate in the study. All 17 participants gave consent to participate in the study

3.7 Data collection

The researcher conducted in-depth interviews using the interview guide (Appendix 1). In-depth interviews provide an opportunity to explore participants' ideas about their experiences and the meanings they attach to these [202].

One in-depth interview was conducted with each of the 17 participants. Interviews were conducted in participants' languages (SeSotho and Setswana), lasted between 45 minutes to 1 hour, and were digitally recorded using a voice recorder. Questions were open-ended, and they explored experiences of SFL including perceptions about what SFL meant to them or views on SFL, a period of participation, training content, delivery method. Questions about the effects of SFL explored messages that were retained and practiced across various learning areas including gender roles, relationships, violence, women's economic empowerment, and decision-making, sexuality and HIV.

The researcher held debriefing meetings with the supervisor during the data collection period and provided feedback to the supervisor highlighting key issues emerging from the field and made necessary adjustments to improve the data collection process going forward.

3.7.1 Role of the researcher

In qualitative research, the researcher is central to data collection and analysis. For this study, the researcher performed all key activities, including data collection, verification of the authenticity of transcription, and data analysis. However, as [203] noted, the researcher affects the relationship with participants and the research process; for instance, the researcher's position, experience or role in the study subject could positively or negatively influence their relationship with participants

or the research process. Participants may report what they perceive the researcher would like to hear as retained ideas and practices or what is socially acceptable or overstate challenges. Therefore the researcher needs to account for reflexivity and positionality in the study [204].

The researcher in this study was a 39-year-old black married woman with 16 years of experience working in diverse communities on GBV and HIV. She had worked for the IMAGE project as a director and had managed the implementation of the SFL programme for the previous 10 years. Thus, she had in-depth knowledge of SFL and was familiar with participants' culture, practices, and language. Her responsibilities included overseeing the project's operational activities which included managing a team of SFL trainers who were responsible to deliver SFL training directly to participants. However, the researcher did not have direct contact or relationship with participants, and her role within the SFL project was not disclosed to participants and she had not met the participants before approaching them for interviews.

She also had experience in conducting interviews on sensitive topics like GBV and HIV, having performed three evaluations of the IMAGE project but without having ever assessed the SFL component. Her debriefing experience enabled her to be sensitive and to handle participants' emotions during interviews to minimize participants' discomfort.

Being a black married woman, within participants' age range, Participants' awareness of the researcher's familiarity with SFL facilitated to establish rapport and encouraged participants to speak freely and openly. Familiarity with the SFL programme enabled the researcher to probe with insight; her experience facilitated analysis and data interpretation. To minimize the effect of the researcher's power concerning participants, the researcher emphasized the value of participants' unique experiences and perceptions about SFL and what it means to them. This increased the participants' sense of control and the feeling of being appreciated during the interview.

3.7.2 Data management

The digital interviews were downloaded to the researcher's personal computer and saved in a password-protected drive only accessible to the researcher. An experienced transcriber fluent in SeSotho, SeTswana, and English transcribed interview data verbatim from Setswana or Sesotho

and translated these simultaneously into English. Transcripts were saved as Microsoft Word documents. To ensure anonymity and confidentiality, unique study codes were used to identify and link each participant's voice file and interview transcripts. To minimize error and bias and to ensure the credibility of the interview data, the researcher checked the interviews for accuracy by reviewing the transcripts against the voice recordings.

3.8 Data analysis

Data were analysed using thematic analysis, generating insight into the data and helping to interpret the conceptualisations informing participants' articulations [205, 206]. The researcher is considered a key instrument of data analysis [207], and their ability to understand and interpret experiences and perceptions is central to data analysis. Their skills are critical to uncovering meaning in circumstances and contexts. In this study, the researcher's experience in the SFL implementation helped in finding nuance and meaning while interpreting the data. Through thematic analysis is perceived to be inherently biased—subject to the researcher's understanding and interpretation of data—the researcher in this study used extracts from interview transcripts to support the themes explored in the findings.

Data were analysed following the six phases of thematic analysis as outlined by Braun and Clare (2006) [205]: familiarisation, generating codes, searching for themes, reviewing themes, defining and naming themes, and writing the report.

Familiarisation: To prepare for analysis, data were organized using Microsoft Word. During this first phase of analysis, the researcher read and re-read transcripts to familiarise herself with the entire data set. She searched for meanings and patterns and began noting her impressions of the data [207]. The researcher compiled a field report and a summary of interviews and shared them with the supervisor.

Generating codes: The second phase of thematic analysis involves generating codes and labels used to assign units of meaning to interview data [208] as well as developing a codebook and conducting the coding process. Coding entails assigning units of meaning to data and reduces data into smaller units of meaning, which helps to reduce, simplify, and organize data into meaningful

units of analysis [207-209]. In this study, codes were generated both deductively using keywords from the study objectives as a guide and later inductively as patterns and specific meanings emerged from participants' articulations [205]. The researcher collated data identified as belonging to the same code and then she developed a codebook based on the list of generated codes. This codebook contained a set of codes and their definitions, and it provided formalized operationalization for codes that guided the coding of interview data [209-213]. This codebook guided the coding of all interview transcripts. Using Microsoft Word, applicable codes from the codebook were assigned to sentences, phrases, and paragraphs [209]. The researcher systematically coded data relevant to the study objectives. The researcher shared coded scripts and discussed initial codes with the supervisor and consensus was reached between them on the meanings of the codes. Each read transcripts and discussed patterns and potential themes emerging from the data and disagreement on the codes was resolved through the researcher re-cording transcripts and refining code definitions accordingly. Inductive codes were used to establish the reliability of text segments to support the codes.

Searching for themes: The researcher searched the coded data for themes, patterns within data that captured something significant about the research question [205]. The researcher examined and grouped codes related to themes responding to the research objectives [207].

Reviewing themes: The researcher then modified and developed the identified themes, gathering data relevant to the themes and classifying them under the appropriate theme. She read through the data associated with each theme to establish if the theme was well supported by data and to establish if the theme fitted the context of data. Some themes were combined while others were expanded into sub-themes [207].

Defining and naming themes: Themes were defined and named according to the topic or aspect of data they captured. The researcher established the relationships between themes and sub-themes to ensure a concise, coherent, logical account of participants' articulations on their experiences and perceptions [205, 207]. The researcher analysed each theme and its supporting data to create an overall narrative.

***Writing the report*:** The researcher produced an analytical report on the themes related to participants' perceived experiences and effects of SFL programme participation. Experiences included accounts of how they felt about participating, that is, what the SFL programme meant to them and their experiences of SFL's delivery method and their motivations for participating in the programme. Themes exploring the effects of participation also included any key messages retained from SFL attendance regarding constructions of gender norms and attitudes, relationships, HIV and GBV, and the perceived effects of the programme about these, as well as any attempts by participants to modify their gender attitudes and behaviour.

3.9 Study strengths and limitations

This study's main strength is that it is seeking to assess the SFL gender and HIV training programmes paired with evidence-based structural interventions to prevent GBV and HIV infection (Pronyk et, al. 2006). Furthermore, it is one of the limited studies that explore the effect of an intervention as experienced and perceived by the participants.

Unlike a quantitative approach, the use of a qualitative approach enabled an in-depth exploration of the meaning that participants attach to experiences. To ensure validity and reliability, interview data were transcribed and translated by an experienced translator, and the accuracy of transcripts was checked against voice recordings by the researcher and supervisor. Furthermore, findings were supported by quotations from participants' interview data.

Attempts were made to obtain a cross-section of women who had participated in the programme for a year, thus providing an opportunity to assess message retention and perceived effects. Participant selection also used 'matching by age' and 'completion' to ensure a diverse group and to minimize selection bias.

Furthermore, the researcher's working experience with SFL added value and insight into the study. It allowed the researcher to have an 'insider'-researcher position thus giving/ providing in-depth insights into concepts, meanings, and participants' experiences, enabling the researcher to produce even richer data. Although the researcher has worked with SFL, she was able to assume an objective stance. She provided critical reflections on both positive and negative aspects of the

programme. She acknowledged the challenges posed by male facilitators which may limit women's open engagement with sexuality issues. Such issues are key in demystifying values that increase women's risk of contracting HIV. Furthermore, she was explicit in indicating areas where SFL showed little or no effect on participants' attitudes and practices, for example, women's complicity with gender norms.

Nevertheless, this study has limitations. Participants were already exposed to economic empowerment programme before participation in SFL and had self-selected to join the economic empowerment programme and may possess some characteristics that make them differ from other women in the community. Furthermore, the study does not have baseline data (perhaps before enrolment in SFL) to enable comparison before and after participation in SFL, particularly around gender norms and attitudes and participants' attempts to practice key messages from SFL and there was also no comparison group (of non-SFL participants).

The sample was purposively selected so the findings from the study cannot be generalized to a larger population. However, the findings are based on the unique experiences and perceptions of individual participants' exposure to the programme.

It is also possible that participants may have been aware of the goal of SFL and may have provided either SFL's desired responses or socially acceptable responses. Furthermore, there is potential for recall bias as interviews were conducted three months after participants completed SFL. However, three months of recall has been found to produce more reliable data than longer periods [214].

3.10 Ethical considerations

The study received ethical clearance from the University of Witwatersrand's Human Research Ethics Committee (clearance certificate number: M161191) before the study was undertaken (APPENDIX 5).

The researcher put effort into ensuring that participants gave informed consent by explaining the purpose of the study, the data collection procedures and how data would be used using the

information sheet (Appendix 2). The researcher also explained that their participation was voluntary and that they were at liberty to withdraw their participation at any time without any negative consequences for them. They were also informed their information would be kept confidential, meaning their name and other identifying information would not be made accessible to the public, as all recorded interviews were anonymized using a unique code and thus could not be linked to the participant's information. The potential risks were explained as was the fact that there were no benefits associated with their participation. To minimize harm, participants were provided with details of local social and counselling support services and encouraged to use them should they need them.

After providing information about the study, participants were offered an opportunity to ask questions. The researcher then sought and obtained their consent to be interviewed and to record the interview using Appendix 3 and Appendix 4. Following the consent process, interviews were conducted in a private space to ensure participants' privacy and confidentiality. Participants were interviewed in the house where loan centre meetings are held. Interviews were conducted after centre meetings occurred. In these communities, loan centre meetings are commonly known as a business platform in which participants are perceived to discuss business-related matters only. Therefore, it was an ideal space for interviews as it protected participants from public scrutiny on their participation in the study and on the interview content.

Interview transcripts were de-identified using unique codes to ensure participants' anonymity and confidentiality and were linked only to the audio recordings (Appendix D). A master participant registers with identifying personal details was kept separate from interview transcripts in a password-protected computer accessible only to the researcher. The register will be kept for two years after the publication of the Masters' research report and subsequently deleted. When reporting study findings, pseudonyms were used for participants' quotes.

3.11 Planned utilization and dissemination of results

The research report will be submitted to the School of Public Health for degree fulfilment, as well as presented to the IMAGE project board and shared with participants through a leaflet after the degree has been finalized. Other opportunities for broader dissemination, such as conferences, will

be explored. This research will help influence how interventions can be tailored to improve participants' experience and maximize desired effects. Furthermore, lessons from this study will be shared with the global field of IPV and HIV prevention to inform future work.

CHAPTER 4: FINDINGS

4.1 Introduction

This section presents the findings from interviews with women who participated in the SFL programme. In addition to the participants' profile, it explores participants' accounts of their motivations for participation, and what SFL meant to them. It further presents participants' experiences of SFL perceived messages, how they have retained and assimilated the ideas explored in the programme into their daily lives including gender beliefs and practices, relationships, health, and economic wellbeing. It also highlights areas where women did not fully embrace the ideas covered in the programme.

4.2 Participants' Background

Table 2 shows 17 participants women aged between 25 to 50 years old, with most aged between 36 and 50 years. All 17 recruited participants agreed to be interviewed, no one refused to participate. Six of the women were living with male partners[2], five were married[3], five were unmarried[4] and one was widowed. Most women had between three and six children, with households consisting of five to seven members, including the women, their male partners and/or children, and/or their parents, siblings, and grandchildren. All the women were unemployed, although they all had a small business as a part of their participation in the IMAGE's microfinance component. Participants' household income was supplemented by regular government social security grants in the form of child social grants, parents' old age grants, or disability grants for children or relatives.

All women participated in the SFL programme as a compulsory component of the IMAGE programme, but their levels of participation varied: almost half (8) of the women completed all 10 SFL sessions, 8 women attended four to six sessions, and one attended only 1 session. Four participants were among the few women assigned leadership roles to serve in the Loan centre

[2] Meaning the couple is cohabitating, although the partner has not paid the bride price to the woman's family and they are not legally married.
[3] Meaning the partner paid the bride price to the woman's family or they are legally married.
[4] Not living with partner but with own parents or family or own place and in an intimate relationship with a man.

leadership committee for one year as the treasurer, secretary, and SFL natural leader to coordinate SFL activities, as envisaged by Phase 2 of the SFL programme.

Table 2. Participant profile

Name	Age	Marital status	Number of Children	Number of household members	The extent of attendance (months in 1 year)	Number of sessions attended	Completion of SFL
Alice	40	Unmarried	0	11	12	10	Complete
Brigitte	25	Living with partner	3	7	12	10	Complete
Eunice	47	Widow	3	6	12	6	Incomplete
Mary	34	Living with partner	6	8	12	10	Complete
Patricia	29	Unmarried	1	7	12	5	Incomplete
Joyce	45	Unmarried	2	2	8	1	Incomplete
Rebecca	45	Living with partner	3	5	12	10	Complete
Dorcas	38	Married	2	4	12	10	Complete
Grace	50	Married	6	10	10	10	Complete
Maureen	38	Living with partner	4	12	6	5	Incomplete
Portia	29	Married	4	5	12	10	Complete
Dorothy	46	Living with partner	5	7	4	4	Incomplete
Martha	25	Unmarried	0	5	9	5	Incomplete
Linett	32	Living with partner	4	7	5	4	Incomplete
Merriam	44	Married	3	6	6	6	Incomplete
Elizabeth	50	Unmarried	3	6	12	10	Complete
Deborah	45	Married	6	3	12	4	Incomplete

4.3 Perceptions about the SFL programme

Women who participated in this study held positive perceptions about it. Many commended it and hailed it as an educational campaign to help women improve their daily lives as Patricia, a 29-year-old mother of one child, suggested:

> *"[SFL is] a campaign to get people to improve their lives and encourages people to know more about issues in life… Things that are there in life [which] we see every day and experience them every day".*

Some women praised the SFL programme as a *"beautiful education"* to the extent that its *"teachings are of a very high standard because they go deep and are based a lot on… things that we often see in life,"* as Alice (40 years-old, loan centre secretary and no child) claimed. Others referred to it as an *"umbrella",* sheltering women to acquire knowledge.

The SFL programme was also perceived as a "*light*" that enlightened them on life and diseases. Some women suggested that SFL "*opened one's eyes*" to new ideas while others admitted to having been "*in darkness*" before participating in the programme.

When asked about the overall value of SFL, all participants overwhelmingly described SFL as having been "*very beneficial",* that they "*learned a lot!"* and that it had *"changed their lives".* Alice reiterated this message: "*SFL has changed my life in a big way – especially at home… I've learned a lot of things from it. SFL has opened up my eyes a great deal".*

Some women perceived the SFL programme as providing better guidance than the laws issued by the local chiefs as Grace (50 years and married) put it: *"In truth, SFL has given us the law better than what the chief has done."* In democratic South Africa, chieftainships are recognized by the Constitution as governing structures in the rural communities. Chiefs have the constitutional authority to rule on matters affecting local communities that relate to religious, economic, political, and judicial matters including wedding and funeral ceremonies, male circumcision and land distribution, and they report on crime and contagious diseases, protect the environment and manage dispute resolution through customary law courts for traditional communities. In the context of Grace's statement, chiefs are criticized for the way they rule over matters that involve

violence against women. Given that in her community such issues are exclusively managed by men and exclude women, chiefs are perceived to enforce existing gender norms that are biased in favour of men. SFL was found to have been more empowering: it provided information that women could reflect on and choose a course of action for themselves. Furthermore, SFL was likened to parental guidance as one woman said: *"SFL was like having our parents come back to us to guide us."*

There was also consensus among participants that their lives had improved since joining the SFL programme as Rebecca (45-year-old loan centre secretary and mother of three) suggested: "*I can see that the poverty and stress I was living under has gone down"*.

4.3.1 Reflections on the delivery of SFL

Many women appreciated the content and nature of the SFL programme. They claimed it provided detailed, factual, and practical information and praised it for not using euphemisms that could have led to ambiguity or vague messages. Alice explained it this way: "*They were not beating about the bush. They gave the right information and the absolute truth."* Women also acknowledged that participation also required serious commitment. They said they had had to sacrifice their time and be prepared for hard work during and between sessions.

Some women also appreciated the way the SFL programme was delivered. They highlighted the participatory methods facilitators used to address both general issues such as culture, women's work and leadership as well as sensitive matters like sexuality, domestic violence and HIV. They commended the facilitators for their patience, skills, and the fun approach they applied during the workshops. Others praised the facilitators for enabling those who were "*shy to talk*" to feel involved, ask questions, complete their work at home and share their personal experiences. The use of teaching aids such as dildos to demonstrate condom use was also valued. Many women indicated that they eventually left the workshop feeling empowered as Eunice, a 47-year-old mother of three, explained: *"[even] if you didn't understand something [in the beginning], you ended up understanding it [at the end of the day]"*.

While there was much positive feedback from women about their SFL experience, some raised negative experiences of the programme. These ranged from their discomfort with discussions about sex, HIV disclosure, and violence against women and children while they were unhappy about the use of male facilitators, that the sessions are short, the limited duration of the SFL training, and that it targets women only.

Some women reported that older women in the SFL groups displayed some discomfort during discussions on sexuality issues often objecting to the sessions when being run by or held together with younger participants. Childless 25-year-old Martha observed, *"when we start talking issues of sex, [the older women in the group] get uncomfortable… start fighting and arguing that 'these children' are asking them questions they shouldn't be asking them*." Hence some of the recommendations given by women in the study included a separation of participants by age groups.

Others related how they were distressed during some SFL activities as these reminded them of personal painful experiences. The most notable was the role plays on HIV disclosure and domestic violence. Portia (29-year-old mother of four) recalled her emotions during the HIV disclosure role play:

> *"[The role play] hurts a lot. To be honest, when the drama was happening, the thing is, I don't know how my spirit was. It's something that happened to me, the way that I was mixed up. It was as if I could just cry".*

A few women were also uncomfortable with having a male SFL facilitator leading the sessions on sexual and reproductive health. They were embarrassed to learn new information about their reproductive system from a man. They said they would have preferred a female facilitator to talk about the female body and sexual intercourse. However, others disagreed. They believed that having male facilitators discussing women's issues implied that these men were caring. Moreover, to some women, discussing sexuality felt natural, it did not deter them, even if it was done with male facilitators. They perceived it to be an important aspect of life. Maureen (aged 38 and mother of four children) explained it this way: "*I feel that these are life matters and they are natural. I was okay with it; I was happy that it was done by a man and a man cared about women".*

Women also expressed concern that the 1-hour sessions were too short and did not allow enough time for their questions to be clarified. Furthermore, participants felt that the one-year programme was too short and that it should be continued as there was a continual need for information. Many participants were concerned about the programme being restricted to women and to those who were enrolled in the IMAGE project. They believed that other women and men from the community would have benefited.

Overall, most women found the SFL programme to be an enjoyable learning experience. "*Come Thursday, we would be really happy because we knew we would be taught… so much!"* one participant recalled. A few women regretted having missed what they perceived to have been some of the best sessions. This could have influenced the perceptions of many women that the ten, 1-hour sessions over a year were too short, they would have liked the SFL programme to run for longer than 1-year. Some participants were keen to transfer their learning by volunteering to work with youth in the community.

4.3.2 Reflections and practices of the lessons from the SFL programme

When asked about the key messages from the SFL programme, women remembered ideas related to gender norms and intimate partner violence; women's role in leadership, their economic empowerment and participation in decision-making; women's sexuality, health and wellbeing, and social support. Some of the women reported having practiced the lessons from these different topics in their personal lives. While most women expressed the findings demonstrate significant retention and practices of SFL messages across various learning areas, however, there were areas where this was not observed among few women across several aspects of the anticipated impact of the intervention: violence against women, women's economic empowerment and decision making and gender roles. Some participants demonstrated complicity with gender norms.

4.3.2.1 Gender norms and attitudes

When asked about their reflections on the discussions held during SFL sessions which related to the role of women in relationships, the family and the community, women in the study highlighted the prevailing social and gender norms that relate to marriage and that influence how women view

themselves and determine their gender roles and expectations within relationships, the family and community.

4.3.2.1.1 Marriage as an ideal and women's role

Being married was central to how women viewed themselves and their positions, roles and responsibilities within their relationships, households and the community. Women reflected on social and gender norms that relate to marriage as one of the idealized and highly valued milestones in a woman's life [24, 215]. Women in the study were also aware that being married was associated with a higher social status in the hierarchy of women in the family and the community and that they accrue respectability from it. In turn, they are expected to fulfil certain roles and conduct themselves following those expectations [24].

Like in other rural communities, women in the Mahikeng study site perceived marriage to be valid if the groom's family had paid lobola[5] to the bride's family. Lobola negotiations were a male-dominated practice where men made decisions about a woman's (material and moral) worth. The marriage was then recognized and valued by the community, unlike women who were unmarried, divorced or cohabiting with their partners. Traditional norms encouraged women to stay married to maintain a higher social position. Women who are not married in this culturally recognized fashion are commonly called by socially degrading names such as '*lefetwa*'[6] and those who are divorced are labelled, '*poa bogadi*'[7]. These women become socially marginalized and are considered to be failures as they have not met the societal expectations of being or staying married, and are allocated a lower social position among other women [24].

The significance of marriage was more prominent in the way women in the study introduced themselves. Women often specified whether they were married or unmarried and, if married, whether lobola was paid for them or they had a civil marriage for which they "*signed*" or changed

[5] "Lobola" is the customary practice of paying "bride price" by the groom's family to the bride's family when asking for her hand in marriage. The process involves price negotiations between the bride's and groom's families until they reach consensus. The bride's father and uncles decide on the price. Each family sends a delegation representing each family to engage in negotiations which usually consist of uncles and aunts from the paternal side.
[6] "Lefetwa" is the derogatory term given to a woman who is perceived to have passed the age to marry. She is usually put under pressure and considered not to have been brought up well enough to be fit for marriage.
[7] "Poa bogadi" is a derogatory term given to a woman who is "divorced" and may have returned to her natal home. It is commonly considered a shame as women are expected to remain married.

surnames or had gone through both processes. Grace, a 50-year-old married woman with 6 children observed: *"I have a husband. He paid "lobola" for me and married me. I've signed - I just haven't been able to go and change my Identity document.*"

Upon reflection on the social and gender norms discussions in the SFL programme, women in the study recognized the societal messages arising from these norms and referred to "laws" often conveyed to women, particularly those who are married, through common sayings and songs that are sung during the wedding, bridal and other social functions.

A common wedding song with lyrics that include the phrase *'mmatswale tlogela dipotwana, monwa tsona o fithlile*' is among the most prominent message contributing to the construction of gender roles and expectations for newly married women. The phrase translates as "mother-in-law leaves the pots, here comes the owner". While the message may sound empowering, it is emphasizing that the mother-in-law can now take a break from household chores such as childcare, fetching firewood, cleaning, cooking and washing clothes for all household members, including parents-in-law and the husbands' siblings. The young bride may be referred to as the owner, but the most empowered position of a woman in the household is that of the mother-in-law. At the beginning of the new wife's marriage, she is expected to submit to her husband, his parents, and relatives, who often have a pre-determined expectation of how she must demonstrate her value. The messages that marriage is not easy, and a married woman must persevere, are often emphasized to young married women [24]. Leaving a marriage or divorcing her husband is not socially acceptable, regardless of how difficult it is, and if a woman does it, she often faces the shame of being labelled and marginalized by the community.

One of the major concerns that women had was the expectation that they should put up with their husband's/partner's multiple female partners, often concurrently. Women spoke with a sense of reproach over the saying "*Monna ke selepe re a kadimana*", a common phrase that means that a man is an axe that can be leaned to the community. An axe is a simple but strong and useful tool for difficult jobs in the household. However, not all households have one and as a result, it is commonly shared among households. The saying simplifies and normalizes the extent to which men could have multiple partnerships. It also refers to the notion that regardless of how she feels

about this, a wife is expected to know and accept her male partner will have other sexual partners. Her acceptance is a demonstration of her obedience towards and compliance with her male partner's needs, decisions or instructions. These include being available for sex whenever he desires it and ensuring that it is pleasurable for him regardless of how many other sexual partners he may have at that time.

Another common saying that women in the study mentioned was: *"lebitla la monna le thoko hatsela, lebitla la mosadi le bogadi"*. This means that a man's grave is by the roadside while a woman's grave is at her in-laws. It is yet another example of the social expectations that women must tolerate men's multiple partnering because they are required to stay married.

When women were asked to reflect on the SFL discussions on gender norms, older women believed that the messages conveyed through wedding songs and common sayings are oppressive to women; they also condone men's abusive behaviour and condition women to tolerate abuse within their relationships since such messages are only directed at the bride and not the groom. As Eunice reflected: *"most of the time in marriages when you get married, the woman is burdened with many rules, laws [she must obey] for the family she is going to, but a man is not given or burdened with laws."* It thus appears that SFL was relevant to older women as it got them to question inequitable social expectations concerning women when compared to that of men.

Messages that imply it is acceptable for a man to have multiple partners were viewed as unfair and oppressive to women, as women are expected to accept and uphold them despite their disagreement or displeasure. As Rebecca indicated: "*Like these sorts of wedding songs we often sing… 'a man is an axe—he gets lent out'… Yet, if you turn it around, you [as a woman] wouldn't want to share your man."*

Women further challenged the existing social norm that expected brides or daughters-in-law to undertake all household chores and exempted mothers-in-law from all household responsibilities. As a result, having a daughter-in-law was associated with a mother-in-law being released from household chores. Therefore, having a daughter-in-law or being a mother-in-law was more appealing. Mothers-in-law take pride in how hard their daughters-in-law work. They contended

that married women (or bride or a daughter-in-law) should be treated fairly as an equal member of the family and not be expected to carry the burden of household chores alone. Deborah (45-year-old mother of six and a mother-in-law) expressed this concern strongly:

> *"This child [the bride] should know that being here means that she too is my child. I should treat her the way I treat my biological children. It should not be that my children and I are in bed in the morning and she is the one who has to wake up and sweep the yard, clean up, do the laundry and cook – all on her own. No!"*

Women in the study further reflected on their plight of a heavy workload both within the household and in their IMAGE business activities and how it affected their wellbeing and intimate relationships. As Dorcus (38-year-old and mother of two, a loan centre treasurer and chairperson of school governing body) suggested "*I work all day unaware. Sometimes when I say that I'm resting, then the father will want me to give him 'spinach' [sexual intercourse]. It [SFL] has taught me that I must rest and have time for them [husband and kids]."* Consistently with this, participants also reported they were taking better care of themselves and were making time to rest. This allowed them time to spend with their kids and partners thereby improving their wellbeing and relationships with their partners.

Others felt it is not their sole responsibility as women to undertake all household responsibilities, but rather the responsibility needs to be shared with their male partners or that their male partners should also help. As Mary (34-year-old mother of six) explained: *"We are supposed to be equal, just like we were taught about both men and women's work. That means there is not work [specifically] for men and women. We should help each other here in the house"*. Some of them were able to get their male partners to help with cooking as Dorcas suggested: *"sometimes when he knocks off, he will say 'let me cook, you will come and help me dish up only'".*

However, women reflected limited retention and practices of some of the SFL messages. Fewer women, in particular, those who were older were of the view that the modern dress code increases the risk of rape for young girls, some held the belief that women should be sexually attractive to men, whereas there are no similar expectations for men. This may have influenced women's conceptualization of sexual expectations before SFL that they should ensure sexual pleasure for

men. Some women held judgemental attitudes towards women who engage in transactional sex without challenging men's roles and use of power in those relationships.

4.3.2.1.2 Women's role: income and leadership

When asked about SFL discussions on women's roles, in addition to household responsibilities, women perceived themselves as playing important roles as providers and leaders, both within their household and in the community.

Women in the study revealed that earning an income, from formal or informal jobs and the IMAGE-related enterprises, enabled them to meet their household needs and made them "breadwinners":

> "*Women play a huge role because you will find a woman when she is from work when she gets home, she is again on her feet, working in the house. She is the [only] bread-winner and doing home chores" (Maureen).*

In their roles as sole breadwinners, women were challenging men's traditional roles of provider and leader and showing they were equally able to perform men's roles. However, women still seemed to be obligated to deliver on their expected traditional roles of housekeeping and childcare as well. This undermines the goal of gender equity and further counteracts the learned lessons in the course about the impact of the heavy workload on their wellbeing and relationships.

Women also reflected on the prevailing social and gender norms related to the social status of women in their villages. They highlighted that it is not commonly accepted for women to assume leadership roles or to have women in leadership positions. This view was encapsulated in the common saying: *"a bull cannot be led by a cow—it will fall into the cliff".* Eunice explained that this saying implied that a man cannot be led by a woman as women are disastrous in leadership positions.

This notion can be observed in how other women discussed men's resistance to women occupying leadership positions in the community. Though she was in favour of a woman being allowed to

become a chief, Patricia anticipated that men in the community would not be supported as they set boundaries which limited women's participation in governance-related spaces:

> "*There are things that [women] can do but with others – boundaries are put up for women. We live in a village. If it was possible to have a woman as chief, I would say, 'Let's rather allow a woman to be chief.' What is lacking is support from the men. You find men saying things like, 'I will not be governed by a woman'."*

By contrast, almost half of the participants believed that women have the capacity for leadership and were already holding various leadership positions in the household and the community. At the time of the interview, some of the women occupied positions of chairperson, treasurer and secretary of the women's groups at the IMAGE loan centres, while others had leadership positions in the community as chairpersons of School Governing Bodies and ward committees. They believed that their nominations into these positions were a demonstration of the community's trust in them. As Dorcus suggested:

> *"Like even now, I'm on the School Governing Body (SGB) at some primary school and at the end of the next year I will be finishing [my term] but they declined that I leave. So right now, they want to pick me..."*

Participants who had assumed these leadership roles claimed that their insights about leadership were enhanced through their experience of the IMAGE project, particularly the SFL component as Dorcus spelt out: "*SFL has taught me that we are all leaders. I realised that there is nothing impossible, everything is possible and here I am [as treasurer]"*.

4.3.2.2 Intimate relationships

Women's reflections on the discussion from SFL's domestic violence session indicate that the session enabled women to make a distinction between harmonious and violent relationships. Women were able to identify necessary actions that can be taken to maintain harmony within relationships and factors that bring about violence within relationships and identified various experiences that constitute violence within relationships and resulting consequences. They further shared or reflected on their own experiences of violence within their relationships and the steps

they have taken to address violence. At the same time, however, some women expressed attitudes and practices that appeared to promote conservative gender norms as strategies women can use to maintain harmony within relationships.

4.3.2.2.1 Building harmonious relationships

Legal and constitutional changes that emphasized gender equality have seen more women entering the labour market. This in turn has caused a shift in gender roles between men and women. Some women have assumed the role of provider and gained control over household finances – roles that traditionally had been men's roles. Unfortunately, in the process fewer men were employed which disempowered them and they blamed women. As a result, women are faced with a challenge to balance their expected traditional roles with new roles of provider and controller of the household financial resources while trying not to upset the already fragile masculine identity. Failure to do so could see men seeing themselves as victims of domineering women and this could result in men responding violently towards women [216].

Participants in the SFL programme identified building harmonious intimate relationships as critical for a healthy and non-violent intimate relationship. Women who participated in the study reflected on ideas about how to do so. Firstly, women identified a wide range of factors that contributed to harmonious relationships. They suggested that maintaining regular contact and spending quality time with one's partner, good communication, love, and respect, were all important to maintain a good relationship. Secondly, they further identified factors that limited or were barriers to good relationships; these included alcohol and violence.

Participants suggested that maintaining regular contact with the intimate partner, spending time with and paying attention to them was a key strategy for ensuring harmonious intimate relationships. Some suggested that if a male partner "*lives far away from me"* they should *"always phone each other"*. Those women who did not live with their partners labelled their spare time, mostly weekends, as the ideal time to spend with male partners and claimed that "*the weekends are his*". These women learned this from the SFL programme which *"taught us that sometimes families get destroyed because we don't give our partners time. We are always busy. Even when*

he would like to speak to you, you are busy cooking and doing the laundry. So, this person feels lonely because he needs your attention."

Most of the participants believed that *"good communication",* "*respect"* and "*love*" are the essential elements on which a harmonious relationship is founded and maintained. Women indicated that it should not be that "*because the father [husband] is [earns] lower than me I will want to suppress his right because my salary is over his*", said Eunice (47 years and a widow). They further suggested that sexual satisfaction was also essential and emphasized that "*love*" superseded having money to keep the relationship going. Joyce explained it this way: "*in life, your relationship with a man should not be based on money. You are going to fail. You should love someone as they are. The only solution that works for a household is satisfaction. Whether there is money or not—if there's sexual satisfaction, life goes on."* According to Joyce, it was more meaningful to love a person as they are than for the money they could provide, and this contributed to healthy relations between partners. Some women held the view that lack of sexual satisfaction legitimized male partners' engaging in multiple sexual relationships which in turn created disharmony in relationships. So, seeking to ensure sexual satisfaction was key to maintaining a good relationship and so prevent male partners' unfaithfulness.

These ideas may have been an outcome of women's reflections about the deeply entrenched social norms and practices that condoned male multiple partnering despite the risks it posed for women such as HIV infection. Women stressed that *"honesty is what builds two people".*

Other women highlighted the importance of male partner provision for the household to maintain good relations with his wife: "*The man doing all that he needs to—giving you money so you can buy food, dressing you and the children well. This is when there is happiness in the home"*. This is consistent with social and gender norms about men being heads of households who are expected to financially provide for their families.

Women also identified barriers to building harmonious relationships and highlighted men's alcohol abuse and men's jealousy. Some women like Patricia believed that "*We would be happy together if he did not drink (alcohol)"*, while others like Dorcas blamed her sense of bitterness

towards her partner was due to her experiences of him when he was drunk: "*You see with me, [the relationship is] bitter when there is alcohol."* Other women mentioned that their partners/husbands were sometimes suspicious that they had other male partners. Prevailing social and gender norms forbid women from having multiple partners and the idea of one's female partner dating other men threatened men's sense of dominance and control over female partners.

A few women transferred their ideas on how to build a harmonious relationship with their daughters. Rebecca reflected on what advice she had given her daughter, a university student, on how to establish a stable and good relationship: "*I tell her, try to find someone who will be honest with you and stick with him as a boyfriend and talk about these things."*

However, not all participants seemed comfortable going against social norms and creating equitable gender roles in the relationship. Women perceived that although they were financially independent, they needed to remain respectful to their male partners, thereby upholding patriarchal values and social norms of being an obedient wife. Maintaining respect in these ways was to protect themselves and minimize the backlash from partners which often manifested in the form of intimate partner violence as Alice explains:

> *"I think that is a good thing that women should work and generate an income, but it should not be that I should not treat the man of the house well. I should be a good woman always, even though I earn more than my husband, or I am working, and the man is not working." —Alice.*

However, remaining obedient to prevent violence is complicit with patriarchal gender norms and undermines gender equality. Grace argued that a woman should not undermine her husband, nor should women say things like: "'*I'm the one who is bringing an income and who does everything. All you do is eat, wash and sleep with me while I'm the one who supports you'…. Even if the father does not work and drinks – you should still humble yourself before him as your man."* However, this promotes inequitable gender roles within the relationship and undermines the goal of gender equality.

Furthermore, women identified good communication skills as central to building harmonious relationships, to achieving joint decision making and resolving problems. Partners speaking to each other with respect and without fighting was key to achieving a joint decision. Some women were proponents of good communication, as Rebecca indicated, she encouraged that partners should *"sit down, talk and agree. The most important thing is communication. You must communicate"*. Dorcus was among the women who applied communication in her relationship and this positively influenced decision-making with her partner even before participating in the programme: after getting married Dorcus and her husband decided to buy a plot and build a two-roomed house as opposed to renting. Her partner was worried that his income was inadequate but every month they saved money to buy materials and later they were able to build a nicely furnished house with a kitchen, lounge, bedrooms and a garage. Dorcus claimed that she reminded her husband their success was due to their earlier discussions and would tell him that *"everything works per budget and don't make the decision by yourself. Let's sit down and talk".*

Almost all women reported having learned about communication to solve problems in their relationships, within the household, among peers, and in the community. They highlighted lessons on listening, being patient and managing their emotions and suggested that this helped them to learn how to handle problems better compared to the previous responses such as shouting and using physical violence. Some even commented that "*listening pays"*.

One of the participants also claimed that the programme helped her improve how she disciplined her son, having stopped the use of physical punishment. Elizabeth explained these changes:

> *"We've been taught to speak kindly… not to be rough. It's helped me in the home with my boy. I'm loud and quick with fists. Before the SFL programme, we would be loud and would beat him up. So, when they started teaching us, I started speaking nicely to him and he understands me. He's also given me a break. He no longer smokes and comes home late".*

Some women also applied communication skills to resolve IPV problems within their relationship. For instance, Dorcus and Portia communicated with their partners to address their experience of violence from their partners. Rebecca implied that had she received the SFL messages earlier, she would have solved the problem more constructively:

"If I knew about the SFL programme, the problems would have found me ready and prepared… Right now, I feel that SFL has taught me that there are challenges in life and there are ways how to handle them. I take it I would have sat him down". (Rebecca, 45).

4.3.2.2.2 The violence women faced

When asked about their reflections on the SFL sessions, many women recalled the session on domestic violence. They especially remembered new knowledge about different types of violence against women, women's experiences of violence; the prevailing social and gender norms that influence IPV and the various steps they took to support women who experienced partners' violence and to stop it within their relationships. Some women admitted that they used to hide their experiences of IPV and did not speak to anyone as they were afraid of gossip.

Following their participation in the SFL programme, almost all women in the study raised emotional, physical and sexual abuse as common forms of violence that they experienced at the hands of their male intimate partners. However, some women described how they were surprised that certain behaviour by their partners constituted abuse. As Merriam, a 44-year-old, a natural leader and mother of three, explained:

"[SFL] taught us about domestic violence and some [of it] we don't even realize that there is something that happened [to us] that is not good. It's like we are used to it but it's something that is also domestic violence. The thing is, [SFL] has opened my eyes."

They had been unaware that abuse was not limited to physical partner violence but sometimes involved men's refusal to financially support their wives and children. Rebecca (45) described it thus: "*We didn't know that when a man does not give you money that this is abuse. Even if he doesn't beat you up."* Given the deeply-rooted patriarchal system where men have control over women and household finances, women's dependency on men is sustained by prevalent messages such as: *"a man is not asked for a payslip*", which warns women against enquiring or challenging men about how they use their earnings

This lack of knowledge of the different ways male partners can be abusive towards women may have consequently limited the ability of women who were experiencing acts of partner violence, to act against them [24].

Eight out of the seventeen women reported experiencing violence from an intimate partner. Four out of five of the married women who participated in the study indicated that in their marriages they had experienced a range of physical, sexual, financial and emotional violence at the hands of their male partners for a long time. Acts of violence from partners included being "*beaten up*" in front of the children, being *"pointed with a gun"* and forced to have sex when they did not want to. Joyce (45-years-old mother of two) explained: "*he would force himself on me during my [menstruation] periods".*

It appears forced sex was also used to silence women from asking about their partners' suspected multiple partnerships and to threaten women not to refuse to have sex. Grace described her experience in this way: "*When he comes back and wants to sleep with you, he beats you up and threatens you, so you can sleep with him."*

Some of the women were abandoned by their partners with children and did not receive financial support from partners and were not able to meet the household's needs. Eunice (47 years and mother of three) explained: "*when it's month-end he doesn't give me money, he doesn't buy food in the house …I don't know what I'm going to give the kids, and I am unemployed*". Furthermore, one of the women felt betrayed when she discovered that her partner had a child with another woman. Joyce's (45 years and unmarried mother of two) partner *"denied paternity of the [her] child. Even after we had gone through DNA testing that proved that the child is 100 per cent his. For many years, he refused to provide maintenance for the child".*

Participants attributed their experiences of IPV to the social and gender norms around marriage including messages targeted at women about their expected roles and behaviour when married. For instance, there is a common perception in the community that when a man marries, especially when he has paid *lobola*, 'he owns the woman'. During *lobola* negotiations with the woman's family, her level of education often determines the amount of money expected by her family and,

if she is educated, a higher amount is often seen as compensation for the costs of her education. Similar logic is sometimes applied whether she is employed or not. Thus, *lobola* is viewed as payment for these attributes a woman may bring to the marriage. It fuels the perception that the man should have control over the woman's ability to earn income, and if she has income, how it should be spent. On the other hand, the man is expected to use his discretion on when and how he disburses his income, although he is expected to be the breadwinner in his household.

Other women further blamed gender norms communicated to women when they get married that, in their view, force women to tolerate violence and to stay in abusive relationships. For instance, Eunice recalled a roleplay which depicted gender norms, married life and violence against women and likened it to existing experiences that women currently face in their lives: "*these things happen in our [household], but we keep being women [persevering] and dying on the inside; we die for the vows that we made in our marriages*".

Women also reflected on the potential effects of IPV and the consequences for children if violence is not addressed. They highlighted the effects of violence on the poor emotional and physical well-being of women, and the poor school performance of children.

Participants suggested that there was a common silence among women in the community surrounding their experiences of violence by male partners and this may have been due to societal expectations for women to tolerate and persevere despite suffering abusive relationships and not to speak about the marital problems to people outside their family. Such an action would expose their household problems to the public and that would bring shame to the family.

Some women made connections between women's exposure to partner violence and emotional ill-health and attributed this awareness to lessons from the SFL programme. Rebecca suggested that her colleague's silence about her experiences of violence by her male partner inevitably led to her diagnosis with post-traumatic stress disorder. She explained:

> *"The doctor said she has something like post-traumatic stress because she lived in this oppressed state but didn't say anything. When we were with her, we saw things as normal.*

She pretended as if things are fine. Once we leave, she's left in 'coal' [a bitter situation]. By the time she spoke out, it was already late." (Rebecca, 45).

One of the women, Dorcus, believed her partner deliberately impregnated her so that, consistent with local cultural norms that prohibit sex with a pregnant or breastfeeding woman, he could justify his multiple partners. This resulted in unwanted pregnancies for Dorcus (50 years, married and mother of 6) as she reflected "*he gave me these three children – This one from '94, then '96 and '98 – can you see that they don't give each other any chance? …When I'm pregnant he leaves [abandons] me. If I'm breastfeeding, he leaves me [for other women]. That's when he would get his chance.*

Some women reported on the consequences of intimate partner violence on children. Eunice noted the burden that the violence had on children and how it affected their concentration: "*It gives the kids problems …when at school and the teacher teaches, he is thinking of situations at home and it burdens the kids and he performs poorly at school."*

Some women reported that before SFL they took various steps to address experiences of violence. Some sought help from in-laws, neighbours and friends, laid criminal charges; others would defend themselves by shouting insults at their partner.

Those that sought help from the in-law's family found their efforts were fruitless. The husband's family instead blamed the woman as the cause of men's violent/abusive behaviour. Dorcus (38 years) lamented: "*when I go crying at his home they would listen to him and they would always think that I'm the one at fault So, I ended up not saying anything… at his house, they weren't helping me."*

This type of response from in-law families reinforced social messages that women must tolerate and endure violence while men's violent or abusive behaviour was condoned.

Half of the participants reported that after attending the SFL sessions, they had realised the importance of taking steps to address IPV. They suggested a range of steps namely sharing their

experience with a trusted person or a social worker and asking for advice, addressing it with the abusive male partner, and reporting to the police. After attending the SFL programme, women who had hidden their experiences of abuse by male partners began to speak up. Portia (29) described this change:

> "*I'm a person that, most of the time when I have a problem, I'm unable to talk about it to other people…but at least after [SFL], I was a person who, when I had a problem, I would then talk to another person."*

Others reiterated the importance of doing so with a trusted person to halt the violence. As Mary (34) suggested, "*If you have a problem in your household, you must talk to neighbours whom you trust… Maybe they can help you to sit down with your partner [to solve the problem]"*.

Women who disclosed their experiences of violence during the sessions offered in the IMAGE project found it overwhelming and emotional. Some felt good that they had finally spoken up as Grace (50) shared: *"There was a day when I spoke up. I spoke, a handful—I nearly cried. I brought it out and spoke openly."* Though the reactions of fellow attendants were not reported, some women suggested that sharing experiences around violence in the group was sometimes received with empathy. Joyce said *"as women, we felt relieved because certain things were happening to people [other women] without us knowing. But when someone speaks with tears in their eyes – you know it's true, that these things do happen."* The importance of speaking up about partner violence experiences was encouraged as it was perceived to be therapeutic and would relieve stress and was believed to strengthen solidarity amongst the women in the IMAGE project.

After participating in the SFL programme, apart from speaking up, many women also attempted to resolve the experience of partner violence, albeit with varying degrees of success. Some women were able to seek help when they were beaten up by their partner; they reportedly screamed and called neighbours to help them, while others sought advice from trusted colleagues.

A few women successfully spoke with their male partners to stop the abuse. For example, Patricia (29, single mother of one child) who had been experiencing emotional abuse by her male partner

reportedly engaged him on his abusive behaviour with the result that he had then refrained from the verbal abuse:

> *"Last time, he ended up saying things that did not sit well with me. I showed him that, 'this is not right because you are abusing me [when] you make these threats.' I sat him down and told him that, 'If you have a problem, sit down with me and tell me what you like and what you don't like.' Right now, we live happily together. He no longer has that thing of using harsh words towards me."*

Others reported that their male partners stopped the abuse after overhearing discussions about domestic violence during the SFL sessions. Dorcas (38, married with three children) described an instance while her husband was sleeping in the room next to the garage where a loan centre meeting was held when he overhead SFL's discussions on domestic violence. He then asked her about the sessions afterward. She reportedly took advantage of the opportunity to explain her perceived experiences of violence from him and they resolved it.

However, though some women were able to resolve the violence through constructive discussions with their male partners, others found their partners to be stubborn and the violence continued. In Mary's case, the problem of violence persisted: *"to tell the truth, I do not have happiness in the house, it is only problems! Perhaps [it would have been resolved] if I had a different person".* Mary had a long history of violence at the hands of her husband with whom she had had 6 children. She was struggling to access the child social grant as her husband was a foreign national and was not helping her with the situation. Her attempts to involve social workers to resolve the violence as well as visits to the victim empowerment loan centres yielded limited success.

Moreover, the extent to which some women could handle talking about painful experiences varied. One participant refused to respond to questions on violence against women and HIV during the interview. Bridgette (25-years-old and mother of three) even recommended that the SFL programme should not address issues of violence against women (VAW) but should focus rather on helping women with income generation.

Nevertheless, SFL discussions on VAW and abuse made the bulk of them aware. They were also taught to be assertive and to ensure that they participated in economic activities, so they could assume control over their earnings and secure their economic wellbeing. Hence some of the women were able to keep their savings or earnings and to decide how they wanted to use those to meet both personal and household needs.

Furthermore, some participants were reportedly approached by friends and neighbours for advice or requested to intervene in their abusive relationships and had assisted in resolving the problem of violence in those relationships.

However, some SFL messages around violence against women did not translate into a change in attitudes or practice among some of the participants. For example, a few older women continue to hold the view that the way young women and girls dress increases their risk of being raped. Grace suggested that:

> *"girl children do not dress appropriately… Once she starts growing a little bottom and a little breast, she wears very short skirts that are over the top. That is the sort of thing that invites rape—it causes rape."*

Grace's utterance indicates that critical reflection on gender norms did not occur to all participants. These kinds of conservative ideas which frown upon the modern perspectives and fashionable dress code among young women and girls are widely held in the community. Some women addressed the different ways in which women made themselves sexually undesirable to men and suggested the importance of hygiene, grooming, and dressing well which highlights that while women made critical reflections on gender norms, the same cannot be said for all participants. Eunice (47) criticized women for "*not taking care of themselves*":

> *"We as women, we will be letting ourselves off! No man will just love a woman wrapped in a towel and while sweating with her breast going the other way in a nightdress since morning! You must bathe and dress well so that when the father returns, he finds you well and when you are nice and neat."*

Eunice's ideas about how women presented themselves mentioned above also reinforced the social and gender norms where women and girls are expected to be (sexually) attractive to men while men are not put under the same pressure. This notion of a woman presenting herself well for her man cannot be divorced from ideas that objectify and shame women's bodies. Such ideas can increase women's vulnerability to violence. Eunice's statement also suggests that women may not seek to be presentable for their sake but the pleasure of men. The idea of objectification and shaming of women's bodies is also encapsulated in how older women like Grace spoke about women's sexual risk being associated with how they dress in revealing clothing.

4.3.2.3 Women's economic empowerment and decision-making

The IMAGE project was promoted to potential women participants as a women's economic empowerment programme to enable them to earn income and be financially independent. The SFL component was added to build capacity and skills for the personal agency as well as to positively influence women's participation in financial decision-making in their household.

All IMAGE participants were unemployed at the start of the programme. They reportedly joined the IMAGE project and its SFL component because they wanted to address the limitations that financial dependence on men for money and other material needs to be placed on them.

They had struggled to meet personal, household and children's needs or to contribute to household decision-making particularly over how income was spent in their households. Some women expressed that before joining the programme they felt that male partners were controlling them and were oppressed to the extent that it *"made it impossible for women to have a say"*.

Women in the study described how male control and oppression manifested in ways that victimized women. For example, some men were said to have chased women out of the house as they often had sole ownership of the house they lived in together. Others sexually abused female partners or accused their wives or live-in girlfriends of being after their money and often scolded them for not finding work. Eunice (47) described her experience where her husband used to accuse her saying, *"You are just sitting here waiting for my pay and you want me to work for you. A good*

woman goes to work!" This notion that women should find work is consistent with ideas that promote gender equality, however, when invoked in this way they constituted insults to put women down as being parasitic.

More than half of the women in the study, mainly those who were older and those who completed SFL, felt women can make decisions and should be allowed to do so by their male partners. They challenged the dominant notion among male partners and the community where only men are perceived as heads of households, breadwinners and thus the ultimate decision-makers. In practice, this translates into all men in the family and community exercising varying degrees of control over women either as husband, fathers, uncles or chiefs. This is further expressed through the idea that their word is final whereas women's ability to do the same is undermined or disallowed.

Some women contested the notion of men as heads of households and proposed that *"there is no such thing when they say the husband is the head and the wife is the neck. There is nowhere that this head can go without support from the neck. This head is controlled by the neck, [it] can't function [without the neck]."* While they acknowledged the superiority of the head as the base for sensory, cognitive, and decision-making, they pointed out that the head is dependent on the neck as a support system. However, though this symbolic comparison presents women as a prominent and necessary entity, the notion of women as supporters of men is also a conservative perspective. It does not completely portray women as capable of leadership and decision-making in the household around budgeting, purchasing, and making other important decisions on the same scale as men.

Participants also justified the need for women to be financially independent emphasizing that women are much more aware of the needs in the home and have more experience and confidence as mothers and wives to advise on how to address these. Rebecca advocated for increased financial independence of women suggesting that: "*She needs to be very involved in the family's income. She's the one that sees what's needed in the home. She needs to know when the money comes in—she sits down with a man and tells, 'We do this'…She is the one that oversees the family"*.

However, the notion that women have ample oversight over their families is drawn from the gendered expectations on brides, wives, and mothers to nurture and care for others in their home upholds the traditional gender roles [24]. Women perceived themselves to be capable of making effective decisions that were more workable than men. They also suggested that men felt threatened by women having opportunities to make decisions as women's inputs usually worked well [216]. Patricia challenged: "*Often, men don't like it when brilliant ideas come from women. [Men think] it's as though 'this woman will no longer respect me in my home anymore'"*.

This was also found in other studies. These studies found that women who ascribed to values of acquiescence femininity were less likely to be able to make decisions as power was vested in a male partner; whereas women who ascribed to resistant femininity were more easily able to make decisions [217].

Being financially independent was perceived to give women a sense of pride: they were earning their income and had the freedom to use their own money as they wanted. Nearly all the respondents are black, poor rural women. They were previously economically underprivileged and financially dependent on men and their role had been restricted to housekeepers and child carers for most of their lives. Being financially independent made them *"happy"* and gave them *"pride"*.

> *"It makes one have pride. To be proud of being a woman of today. Because in the past, a woman would cook for the man – wash for the children, bathe the children. That was your job. But right now, at least we have the opportunity to run your business and sell whatever you are selling – move forward and improve your life. A woman's life is not only in the home, but it's also everywhere" (Patricia).*

4.3.2.3.1 The importance of earning an income

Earning an income was also associated with decision-making power and control of household resources. Many women suggested that women's financial independence and increased decision-making power were more attainable if women earned an income either through running a small business or being employed. Some women equated having access to income to 'living' as they believed that *"(money) is something you cannot live without"*. Women also mentioned the positive

impact of them earning income independently from their partners. They suggested that it contributed to women's participation in financial decision-making in the household. This facilitated progress in building or renovating their house and buying large assets. Moreover, generating their income through the IMAGE project gave participants a sense of emancipation, pride, and agency and enabled them to improve their lives instead of being controlled by male partners. Their new-found pride and agency enabled them to find better ways of disciplining their children and facilitating their children's marriage.

Women were critical about how men prioritized household expenditure drawing on the differences in how women and men spent money. They suggested that men were often preoccupied with spending on their individual personal needs whereas women focused on the family and their household. For example, men often chose to spend money on alcohol while neglecting their families. As Elizabeth put it: "*You'll never find a woman going drinking once she gets paid, but a man goes drinking first."* For this reason, women suggested that having access to their cash would ensure that income was spent where it was most needed.

Women's financial independence was perceived to be instrumental in enabling women to overcome male control and oppression and to gain control over their lives. Most participants believed that earning their income alleviated them from control and oppression by male partners. Some invoked the term "*50/50*" which became common in South Africa during the 1990s when the post-apartheid government introduced the national policy on gender equality. This was to ensure women's emancipation from poverty by, for example, increasing women's access to jobs with equal pay with men and so on. Women in this study believed that women should be allowed to make an equal contribution to household income and decision-making. They also believed that earning an income emancipated them from male control and oppression as Mary explained:

> *"Now [the dispensation] is 50/50 (between women and men), you may not stay and wait upon your husband. You are compelled to work for yourself because if not, he will end up oppressing you… Let's say you live in his house, he can chase you [out], maybe he wants to sleep with you when you do not want, and he will force you."*

Earning an income was also important for both married and cohabiting women with working male partners to supplement their male partner's income as "*right now, the cost of living is too high"* and *"you find that the man is working for a low income and it can't cover [all household expenses]."* But for other women, financial independence helped them when male partners did not provide financial support for them and their children.

Many acknowledged that women's ability to earn income was sometimes limited by male partners who did not allow women to work for income as these men held conservative ideas about a woman's role. Dorothy, a 46-year-old and mother of five indicated, "*It's not every [man] that allows the [woman] to go work. Many [men] say that I work as the man so you as the [woman]) sit down and work [in the home] for the kids".*

Women's ideas about financial independence were also applied to women's interpretation of the currently absent role of women in *lobola* negotiations. Traditionally among many black South African communities like Mahikeng, the mother of the bride or groom does not have a say in *lobola* negotiations *per se* as this is a domain of men in the family: the father, uncles and sometimes the aunt joins this delegation. However, women felt it is an important decision that they should have a say in as equal partners and parents of the bride. They believed they should jointly agree on the price and then inform the mediators who are usually uncles and aunts. As expressed by Eunice:

> *"The child is getting married, so we discuss how much we want for our child for her 'lobola', it's me, the mother and the father before we go tell the aunt and uncle that please go for us that side and tell them we want this much for our child. The wife and the father's [male partner] household is a household for two people. The husband and wife's word are one person's word (it should be one voice, or it should be a joint decision."*

While the mother could contribute to decision-making or the *lobola* negotiation process which would serve as an example of communication and achieving joint decision-making among couples, however, her participation may indirectly support men's oppression over women since the *lobola* process or customs are created to sustain male domination and control over women. Moreover, these customs serve men or put them at an advantage over the daughter or bride herself. For

instance, the price takes into consideration how well she has been groomed to be an obedient bride, wife, and respectable mother. All of which serve the interest of men and in-law's family than herself, thereby indirectly perpetuating gender inequality and counteracting the goal of SFL.

Whilst the majority of the women in the study believed that economic empowerment went hand in hand with the power to make decisions, a minority of the women particularly younger and cohabiting women felt that it was inappropriate for women to participate in household decision-making as that challenge men's authority as heads of households and may trigger violence. They accused the other women of challenging the culture of men as decision-makers and referred to them as women who are *"showing their heads*" meaning they are stepping into men's 'territory'. They perceived women who make decisions as rebellious and challenging men's control. Dorothy (46-years-old and mother of 5) described it this way: *"In a certain culture, it's the men who are controlling and other women show their heads, too."* Such women's attitudes are complicit with ideals of femininity, uphold the dominant patriarchal norms [24] and undermine the goal of SFL of gender equity.

4.3.2.3.2 How women exercised economic empowerment

Women in the study related the various ways in which they exercised their economic empowerment in their households after their participation in the SFL programme. Just under half of women reported having practiced some of their learnings concerning savings, making large purchases, paying for their children's education and so on. As Rebecca recalled:

> *"SFL encouraged us to save money for those really important things in life. As a mother of a 25-year-old firstborn, who is studying at university and often struggles financially, I have found that since being part of the project* [8] *my profits and savings are now able to help [my son] out."*

One woman had used earnings from her income-generating activities to build a carport as a surprise for her husband. Another used her income to replace damaged prescription eyeglasses for her child.

[8] The Small Enterprise Foundation is the microfinance company that administers the microfinance component of the IMAGE programme for income-generation purposes.

She paid cash which she felt she would not have been able to do had she not learned and practiced savings after participating in the SFL programme.

Based on the success of their income-generating activities, some women invited their female relatives to join the IMAGE programme to start their small businesses. This worked particularly well for those women whose relatives were financially dependent on them. Other women reported how the SFL workshops influenced them to start budgeting for large projects or purchases such as building or renovating a house, working together with their male partners as previously seen with Dorcus.

On the other hand, some women faced challenges in implementing their learning as their assertive approach to financial decision-making was perceived as conflicting with men's desire for control over their female partners. Merriam, a 44-year-old mother of three and an SFL group leader, related a story of how she decided to build the carport for her husband as a surprise, only to offend him by doing so. She had not told him about her plans, and he was ultimately unhappy with her even though she had used her money for him. She explained:

> *"My husband is a person that likes [to] control, so if I do something [without his permission] like the carport that I did there… He asked why as a woman I did it without [his] permission. Whereas I feel that it was a [good] surprise and then it turned into something sour."*

Merriam's interpretation also suggested that she was aware that her husband was controlling, and it appears that she went ahead without his permission as she had anticipated his resistance would curb her ability to achieve her project. Going ahead without his approval is consistent with some women's notions that men are often uncomfortable with women making decisions about large or important purchases as they sought to control not only women but also how they spent their own money.

4.3.2.3.3 Building supportive social relationships

There was a prevailing perception among participants that women were not supportive of one another. They gossiped about one another, made snide remarks behind one another's backs and

called one another degrading names that often related to men's multiple partners, dating other women's male partners or women's infertility.

Women suggested that the gossiping and the degradation meted out against women who were struggling to bear children depicted their lack of support for one another. Snide remarks were reportedly made indirectly through traditional songs and common sayings, to inform a woman that her boyfriend or husband had sexual relations with other women and often to boast that there was nothing she could do to stop it. Dorcus offered this expression: *"a man can't be fetched from another woman's place"* in addition to the one that says, *"a man is an axe, so he can be borrowed"*.

Such sayings worked much like maxims which were meant to establish rules of conduct for women to tolerate male multiple partnering. However, they also constituted indirect *"insults"* towards women whose male partners were cheating while the woman would be *"think[ing] that they are just singing"* and yet she was being indirectly informed, "*that you must know that today… he will be at the other woman's place."* It appears that the gossip and degrading of women was done by other women and sought to perpetuate ideas about male sexual entitlement and the expectations on women to bear children in both situations, without challenging either men's cheating practices or their roles in infertility.

However, following SFL, women reflected on the effect of such a lack of support. More than half of the participants reported having learned through the SFL programme the importance of women supporting one another and how doing so had the potential to build their communities.

Women's involvement in multiple partnerships increases their risk of IPV within their relationship and condones men's involvement in multiple partnerships. Women recognized that engaging in multiple partnerships, degrading one another through insults, snide remarks, and wedding songs, perpetuate competition and rivalry among women and contribute to a lack of support for each other. They further realize that they contribute to their abuse and expose themselves to further abuse by men. Dorcas (38 years married) explained: *"We as women, we insult one another with words._We are the ones who are always abusing one another……. these things that we keep*

doing on the outside [multiple sexual partnerships] are not good and we will be abused by men". She further encouraged them "*not to pick on one another"*.

Consistent with these retained messages from the SFL programme, a few women, mostly those who were older and those who had completed SFL, reported practices where they demonstrated support for fellow women through expressions of love and by not picking on or calling one another degrading or humiliating names. For example, some women encouraged this new way of relating with other women as Grace indicated: "*Calling a woman who cannot bear children's names…is not a good way of speaking to people. Right now, you can speak to someone in the street without being loud and shouting profanities. That's how SFL has taught us."*

Other women promoted the idea of women giving one another advice on how to sustain their income-generating activities as Rebecca implied: *"I would even encourage one to say that if the loan you have (from the IMAGE project) is putting pressure on you, or your business is not doing very well, rather go down (take a smaller amount) so you can save."*

They believed that when women work together as a collective, they become constructive and can achieve their objectives. For instance, some perceived women as being capable of community development and could do so by disseminating the SFL messages within the community. Others believed women could group themselves and run "*vegetable gardens and poultry projects"* which could help to improve the economic conditions of their households and communities. Grace had observed how this occurred after participating in the SFL programme: "*Before we had SFL, women were scattered. Right now, women can group themselves and start things that benefit them that make sense, like the savings groups."*

In South Africa, savings groups have been proved to be instrumental in enabling women to save and meet their needs as well as provide support to fellow members [24]. They are part of a social network system that is built on relationships of trust and can help women participants to meet their economic objectives. In those groups, women know one another and there is a sense of solidarity and support amongst them [39].

Women narrated other ways in which they supported others in their community. Some women advised women who were experiencing violence at the hands of their male partners. Consequently, Eunice reported having received positive feedback about the effect her support had on abused women in her neighbourhood. She explained:

> *"Most of the time, the people that I help are the ones that come to me with domestic issues. When they have a problem with their men, I'm able to guide them… Another woman came to me the other day and said, 'I thank you because most of the time when you go to my house to caution us, you do not take sides. You guide all of us, me together with that man...'"*

Some women also encouraged other parents to take children to school. Others offered practical help, such as looking after someone's baby for a month while the mother was hospitalized, providing transport to loan centre meetings, and assisting families who lost loved ones and did not have money to secure mortuary services. Deborah assisted one family to bury their loved one: *"We had a death next door [and the people had no insurance. We came out, checked the situation, and decided that the corpse cannot stay in the house because it's hot. I then said, 'What I will do is find a mortuary for you.'"*

Some women reported having provided moral support to friends and youth in difficult situations. Examples included supporting a friend to disclose her HIV positive status to her mother and providing a "*shoulder to cry on*" for young people who were experiencing various problems in the neighbourhood.

Other women reported how the SFL programme helped them to handle their difficult situations. Elizabeth had been looking after orphaned children who were placed in her care, but she was not ready to do so. She related how the messages from the SFL programme helped her realize the type of person she was such that she accepted the children: *"If this problem came up in 2014 or 2015 before SFL, I would have refused and said, 'let them see to finish' [see to themselves]."* This suggests that Elizabeth may have also learned to be more caring about those in need.

Women also spoke about how rewarding it was to provide and receive support from others. Those who supported people diagnosed with HIV received positive feedback from them on how they had helped them adjust to their positive HIV status. This was Grace's experience where "*a person is now using condoms and is now taking their [ARVs] and they come to thank you for saying, 'If it was not for you, I would have given up on myself and was going to die. I was scared'."* Mary also expressed appreciation for the support she received from her neighbour during a violent incident with her partner, while Rebecca felt that the support she received from local women with whom she attended the SFL programme, helped her to adjust to the new environment and life following her divorce and relocation.

However, a few young and unmarried women who felt they could not trust the community and would rather turn to established institutions like traditional leadership or community policing forums for help in time of crises as one of Linette (35 years, living with partner and mother of four) articulates: *"there are people that work with the kingdom [traditional leadership] ... and police forums and when there are problems you can run to them to tell them about that problem and they can help you with it".*

Lack of trust in social relationships could be attributed to fear of having their problems being broadcast or gossiped about in the community. There were several qualities that participants believed women needed to have to provide adequate support towards one another: "*if someone tells you something, you need to keep it to yourself"* is instrumental in encouraging supportive relationships amongst women, particularly in communities where women are perceived to be gossipers. More than half of the participants suggested that good social relations among people in the neighbourhood as well as friends and family implied that people needed to be approachable, trustworthy, and helpful, and doing so earned them high levels of respect and trust as community members confided in them about their problems. Alice enjoyed the respect and trust of her community as she sought to listen, advise and lend a hand to people in her neighbourhood as she exclaimed: *"In the community, I live well with others to such an extent that many people have faith in me. I often ask myself why people can share their situations with me. The support I give is that I listen to the problem that the person is presenting to me and give advice where I can."*

Despite the stated commitment to building supportive social relationships amongst women and ceasing snide remarks made about other women, there were women in the group who still judged other women on how they accessed income from men. They distinguished between women whom they perceived to be 'earning an honest living' through work and those women whom they labelled to be "*selling their bodies*". They implied that women who received money from male partners were similar to sex workers as they believed these women changed partners often and accused them of putting themselves at risk of acquiring HIV and other sexually transmitted infections. Eunice explained the concept of transactional sex in judgemental ways that did not consider the broader context within which this occurred. Women were blamed for participating in these practices but did not judge men's participation. She asserted:

> *"What's not good is that when you are a woman, you go sell your body…you end up with an illness…and you are now not a woman in the community but just a thing that is known [used] by any man. How are you going to be exemplary to your kids?"*

4.3.2.4 Health-related matters

When asked about the health information they recalled from the SFL programme, many participants recalled many topics such as sexual and reproductive health, HIV and AIDS as well as emotional and physical well-being, cancer, diabetes.

4.3.2.4.1 Sexual and reproductive health

Women were astonished to learn about the physiological process behind menstruation. Sexual and reproductive health matters, including the biological processes related to menstruation and the relational aspects of sexual intercourse, were among the topics that women were not used to speaking about openly in the community as they are considered taboo. As a result, no explanation had ever been given on menstruation and women recalled what they were told not to do, as 50-year-old Grace indicated: *"When you were still a child—you knew nothing. You just saw things happening down there"*. It is common in rural communities such as the study site, that when a young girl starts menstruating, she is merely told *'not to play with boys'* but without explaining why. As Eunice explained*:*

"[during olden days] when they [elders] say, 'don't do this', you know that you don't have to ask an elder a question and it ends like that, you don't do it when you do it you will then see what will happen".

Furthermore, women were given deceptive messages about the reproduction process as Eunice (47 widows) explained: *"they do not tell you how it happens…mother will tell you a baby comes by a flying machine".* Consequently, it was often when women got married and had children that they discovered certain details about sex and sexuality that the elders held back from them.

This often-left women with many misconceptions about their reproductive system and reproductive health. Menstruation was also associated with uncleanliness and shame among women: women and girls were restricted from going to church or having sexual intercourse.

Women reflected on a range of lessons they had learned in the SFL session about menstruation and sexual intercourse. More than half of the participants treasured the accurate information they acquired about the physiological process involved in the menstrual cycle and claimed that they were hearing about it for the very first time.

The clarifications provided also appeared to have helped some women to calculate their menstrual cycle and understand why they sometimes experienced abdominal cramps or had clots, as 38-year-old Dorcus indicated:

"I didn't know anything about it, to be honest. Like, I always had issues when it came to information about the menstrual cycle. I would be worried that the month will end without me getting a date [period], and I will then get it next month-end and then sometimes, it will be as if it came twice in a month, so Sisters for Life opened my eyes".

Furthermore, many women in the study were unaware that vaginal wetness is natural, and a consequence of women's response to stimulation during sex. Women said if they are "*too wet*" during sex, sex is less pleasurable for their male partners. Dry sex was more enjoyable for men because it added friction and tightness during intercourse. Besides, women said that if one is "*too wet*" it implies that a woman is promiscuous, has STIs, and is using contraceptives and all these

perceptions are socially embarrassing for women. This discussion about their vaginal wetness created some uncertainties amongst the women participants. Some even wondered whether they should be using drying agents as Alice indicated: "*When we have sex, some of us worry about being too wet asking 'is this OK or should I be using something to make sure that when I have sex I'm not too wet?'*".

This question is an indication of the widespread phenomenon of women's use of vaginal drying agents such as "soaps", herbs (aloe), snuff (tobacco), antiseptics liquids (Dettol), ice blocks, salts, fruits, and avoidance of some food and drinks to ensure male sexual pleasure [215]. Such practice is intended to improve sexual pleasure for men; however, it increases women's risk of HIV infection.

Women reflected and challenged the norms that entitle a man to have sex with a woman whenever he wants, even when she is not ready or when she does not want to, and that the onus was on her to make it pleasurable for men.

Women suggested that the discussions during the SFL sessions helped to clarify those commonly held beliefs and misconceptions about the sexual experience which posed risks for them, including the dangers of using vaginal drying agents. Bridgette and Dorcas were among the women who had retained the cautions against "*bathing vagina with soaps*" and reported they had stopped using those. These findings also revealed that women were under pressure to ensure men's sexual satisfaction. Dorcas (38 years and married) "*we were taught that we shouldn't bath [vagina] with soap…. it causes cancers"*.

Women identified that economic empowerment played an important role in decision-making and this extended to sexual matters as well. Alice described it this way:

> *"Suppose the man wants to have sex and the woman is not in the mood to do so. Then, she takes a decision not to have sex. The man should not force his way".*

Some of the constructive learnings on sexual and reproductive health also translated into women sharing the newly acquired information with their daughters and overcoming their fear of having

a pap smear to screen for cervical cancer. Patricia (29 years and unmarried) confidently asserted that:

> "*I was scared of doing a pap smear. Coming to SFL and being taught made me overcome my fear and I told myself to stand up and go and do a pap smear. I went to do it".*

4.3.2.4.2 HIV prevention, testing, and care

Most women also reflected on messages about HIV transmission, prevention, the importance of HIV testing, seeking care early before "*the disease gets worse*", HIV treatment, and care for people living with HIV. Regarding HIV prevention, women highlighted the importance of condom use, negotiating for safer sex with a male partner, and communication with children about sex to prevent sexually transmitted infections and pregnancy. As Maureen remarked:

> *"I learned how HIV enters and how you can prevent it… You have to know your status, so you can be able to take care of yourself, and when you have kids in the home, you have to teach them too."*

Half of the participants reported they had used a condom to prevent HIV infection, with most being younger participants while a few were older women. It is, however, not clear if condom use was consistent.

Those who were married or cohabiting and had completed SFL, reported having learned strategic ways of negotiating safer sex particularly *"sit[ting] down nicely [with a male partner] and tell[ing] him there's a disease that is very troublesome these days".* Grace once suggested to her male partner that it was good to try out new things as she leveraged her "*naughty*" character to introduce the idea of using a female condom:

> *"I'm saying we should use the condom. Now because I am naughty… He then asked me 'so when you were thinking?' I said, 'I want to experience these for women. I will give you the ones for men, so we can see for ourselves. Testing something new in the family is always better".*

It was mostly those women who were in a long-distance relationship who perceived themselves to be at higher risk of HIV infection as their male partners could easily be involved in multiple sexual relationships and therefore suggested condom use to them.

These findings show that when women failed to convince partners to use condoms, they did not give up but went on to pursue HIV testing. Some women asked male partners to *"please go to the clinic to test ourselves"*. Cohabiting and married women may have opted for HIV testing with the hope that a negative HIV test result would minimize the chances of male partners having sex without a condom outside their relationship. Few women believed their partners were faithful. Introducing a condom was associated with infidelity among long-term or stable relationships leading to resistance to the use of a condom.

Women concurred that the SFL programme encouraged them to test. At the time of the interview, almost half of the women reported they had tested for HIV at least once in their lives. Some had done so not long before the interview having overcome the fear of testing as Dorcus claimed: "*I was afraid to go and test because of the way that my life was going. I realized that 'What if I get sick and I'm just sitting?' It gave me the courage that I can go test."* Some women had successfully convinced their male partners to test for HIV even though they experienced some resistance at first. For example, Dorcus's male partner had refused to test several times, claiming to have done so at work, but upon her insistence over time he relented, and they eventually went to the clinic to test together: *"I then told him that, 'Brother, I just went to test… It's not safe for us to sit here like this and not know our status. I encourage you to go.' He gave me a tough time and told me that he keeps testing at work. But in the end, he agreed, and we ended up going [to test] together".*

Testing for HIV also appeared to have helped some HIV-positive women to disclose to their families and male partners and this was attributed to their participation in the SFL programme. For instance, Portia already knew her positive HIV status when she joined the programme, but she was afraid to inform her male partner as it appears, she anticipated the questions "*who brought it*" between the two of them. However, following participation in the SFL programme, Portia reported having been able to persuade her partner to test and, when his status came back saying he too was positive, to take treatment. She explained:

> "*Since getting the teachings I received from SFL, then I decided. I told him we should sit down and talk. I convinced him that we should go for treatment. We went for treatment…*

Right now, he's fine, he's taking his treatment. So, I'm thankful too much to SFL because it has made huge changes in my life" (Patricia, 29-year-old mother of one and a ward councillor nominee).

Similarly, Patricia remarked: *"I feared to talk to people, [that] I'm living with HIV. I had accepted it, but I was not able to speak to people about it unless it was health workers. At least Sisters For Life has helped me because I've been able to speak to my family. I sat them down and explained my situation—even my partner".*

More than half of the women, across age groups and regardless of having completed an SFL, reported having shared information about HIV prevention and testing with family members, young people and male partners, in the home, and the community.

Some women went further and brought condoms to their partners and children as Grace claimed: "*A child will just hear you calling them to the bedroom and saying, 'Here is life… I've brought these condoms home for you to protect yourself"*. Some *"talk[ed] about different diseases"* with male partners and advised that they *"should protect at all times"* by using condoms. However, some women who attempted to share their acquired knowledge about HIV with their male partners and family were despondent as the information "*fell on deaf ears*". Others made time to speak to youth *"about the dangers of not using condoms", "teenage pregnancies" and "how to abstain"* from sex to prevent pregnancy *"basing it all on Sisters For Life"*.

One of the women, Rebecca, reportedly assisted a colleague who had difficulty disclosing her HIV-positive status and helped the colleague successfully disclose to her mother who turned out to be supportive.

> "*There is a friend of mine who recently tested positive… She didn't know who to tell, where to start. [She] didn't have the courage. Then I said – 'if you want, I'll be there so we can talk to your mother'. It was surprising because her mother was never surprised. She was prepared, and said, 'as long as she's told me about her situation, I'll understand what she needs to do; but if she didn't say anything, I wouldn't know'."*

CHAPTER 5: DISCUSSION

5.1 Introduction

This study aimed to explore perceived experiences and effects of participating in gender norms and HIV training, Sisters For Life, that was matched to an economic empowerment programme, IMAGE, among women living in a district in Mahikeng, North West South Africa. The Sisters For Life programme was intended to prevent IPV, address inequitable gender norms, and promote HIV prevention, treatment adherence, and access to HIV care services and practices among participants, in addition to improving women's agency through the economic generating activity provided in the IMAGE component. The study findings demonstrate that many women who participated in SFL appreciated and valued it and found it to be beneficial to them despite it being facilitated by men. SFL contributed to improvements in HIV prevention practices such as condom use and HIV testing, HIV disclosure to family, friends, and male partners, and access to HIV treatment and adherence. Following their participation women also reported improved sexual and reproductive health knowledge and practices, and increased awareness of exposure to other forms of IPV that were previously unclear to them, such as economic abuse, and enable them to share and attempt to address their experience of violence at the hands of male partners. While shifts were observed in how women perceived gender relations in personal relationships and the community, these did not equate to shifts in gender norms per se. The programme's link to the economic empowerment component, IMAGE, was also tangible in the findings as women reported improved financial wellbeing and the ability to meet personal and household needs and participate in decision-making in the household as well as in leadership positions in the community.

5.2 **Perceived experiences of the SFL programme**

When asked about their experiences and perceptions of SFL, women in this study hailed the SFL programme as an eye-opening, educational campaign to address issues that women face in their everyday lives and believed it provided them accurate, detailed, factual, and practical information and allowed them to openly discuss sensitive issues. They also perceived SFL to have been enjoyable, enlightening, and a life-changing programme. Many participants liked the method of delivery of the programme which used fun, participatory exercises, and reportedly felt empowered after attending. They mentioned that the participatory approach highly motivated them to attend

the training. Some women perceived SFL to have been of great benefit and to have influenced changes in their lives, including aspects about HIV prevention, treatment, and care, to respond to IPV, to interrogate gender roles, to understand female sexuality, to have agency in their intimate relationships and to make economically empowering efforts, and to have supportive social relationships. Similarly, behavioural programmes that use participatory methods to promote health, gender equity, and harmony in relationships have been received positively by participants in other studies [194, 218, 219].

However, participants also cited some challenges during their participation in the SFL programme. A few women had difficulties with the session on domestic violence as it caused them to recall painful experiences. While it is expected that interventions that address violence would stir up negative emotions, the said session on the SFL programme had some anomalies. Firstly, SFL's domestic violence session involves a short presentation of violent experiences by an intimate partner through a role play and a discussion of ways women can support one another, hence it may have been shorter than required to adequately address the needs of those who are victimized. Secondly, SFL's domestic violence session is shorter. This is unlike those found in gender transformative IPV prevention programmes where domestic violence sessions are allocated three hours compared to the one-hour in SFL and build on a central thread that addresses gender inequalities, violence, and support over several sessions [220-222], to ensure IPV is addressed comprehensively. Shorter attention to sensitive topics does not allow adequate time to respond to participants' emotions, questions, and needs to be induced by such exercises, and other programmes have raised the importance of mitigating such exposure to participants [218], including ensuring a stronger referral system. Thirdly, the SFL programme had no referral system in place for participants to access relevant psychosocial services during or following their attendance. This is an important limitation that needs to be resolved to ensure adequate psychosocial care and support to victims of abuse participating in SFL. Programmes that aim to prevent HIV, as well as IPV, are inherently prone to inducing emotions and recall of painful experiences, but programmers must take this into account and provide the resources to both participants and facilitators to mitigate the negative effects of programme attendance.

Some participants objected to the use of male facilitators particularly for leading the session on sexuality as it caused feelings of discomfort and embarrassment for some women to learn new information about their sexual and reproductive health from a man. These findings support the view that participants of HIV prevention programmes should be matched to facilitators by gender [223] and researchers also concur in the context of data collection [224]. Matching facilitators and participants by gender provide an open and safe space for women who are more likely to be conscious about their sexuality and maybe current victims of violence to optimally discuss such issues without the fear of being judged. However, other women in this group perceived male facilitators engaging women's sexuality for educational purposes was a sign they were caring.

Age-matching across participants and by facilitators is important to eliminate inhibitors to learning new ideas in sexual and reproductive health programmes [223]. Matching programme participants by age may also be the appropriate approach to address additional concerns that older women in the study raised about discussing sexuality in the same room as younger women. Older participants were reportedly uncomfortable to discuss sexuality issues in the presence of younger participants as they considered it socially inappropriate to discuss sexual matters across these age groups and this may threaten the seniority of older women as cultural norms dictate that younger women should learn about the feminine, and their femininity, from older women or those who have more experience [24]. However, South African literature suggests that sexual communication is complex and sexuality education to young women and girls is often unstructured which may lead to such information being inaccurate or inadequate to address the needs of contemporary young women and girls [191, 225].

5.3 **Perceived effects of participation in the SFL programme**

IPV and HIV were the main outcomes that the SFL programme wanted to prevent, and that women's agency from economic empowerment and communication skills were the secondary outcomes the intervention wanted to improve so that women's economic empowerment could be achieved. Women in the study demonstrated the SFL programme provided useful key messages related to changing gender norms and roles, gender equity in relationships, women's economic empowerment, women's leadership, preventing IPV and HIV infection, and ensuring sexual health,

HIV disclosure, and HIV care. Participants were also able to assimilate key learnings on sexual health, HIV prevention, disclosure, and care into real-life practice. Some women also challenged some of the gender ideologies while others acknowledged the inequalities between women and men, but this did not fundamentally change their gender attitudes. Economic empowerment constituted a major change in women's lives, as facilitated by the microfinance provided to participants through the IMAGE project.

5.3.1 Experiences of IPV

More than half of the participants had experienced at least one or more forms of violence in the hands of their male partners including being beaten, forced to have sex and unwanted pregnancies, and denied paternity of children. Women were also abandoned and also lacked financial support from partners which made it difficult for women to meet their needs and those of their children. This could partly be what influenced their participation in savings groups or their decision to be part of the IMAGE project. The findings also confirm that younger women less than 35 years are at higher risk of experiencing IPV compared to older women (over 55 years) [226].

The findings also demonstrate that participation in SFL improved women's awareness and knowledge about various forms of violence by their intimate male partners, including emotional, physical, and sexual violence and male partners' controlling behaviour [227]. It further enabled some of the women who were previously unaware that different forms of economic abuse and men's multiple partnering constitute abuse to identify such experiences appropriately linked these to patriarchal gender norms, for instance, the expectation that men always have more than one woman at the same time, and women being unable to ask their male partners about their earnings or have access to their payslips [24, 228].

Some women reported having hidden their experiences of IPV owing to gender norms that condone negative male behaviour, convey expectations on women to tolerate IPV, and silence women through fear of shame and gossip, and isolation from other women. Lacking the social capital to have 'someone to talk to' ensured women were silent about the abuse they endured. However, sharing personal experiences of IPV as part of domestic violence discussions in loan centre groups that took place in between SFL workshops also awakened women to discover how

common IPV experiences were among fellow women. It thus appears that SFL provided a conducive platform for older women mostly to break the silence against IPV by sharing their experiences with other women met in the SFL workshops, something they had not done before. Participants reported how this gave them a sense of comfort and fostered solidarity with other women and established supportive networks to exchange advice on how to respond to the violent behaviour of their male partners.

Although women in the study complained about men having multiple sexual partners while married to or dating them, male multiple partnering was not recognized as IPV in the community. Yet, women lamented various consequences of men having multiple concurrent sexual partners that impacted their wellbeing, including exposure to physical violence and having an increased risk of contracting HIV. A male partner having a child with another woman was described as having elicited the worst emotional effects on women due to heightened feelings of betrayal and led to women ending the relationships while others endured the disappointment and later found themselves forced to bury male partners' children. Some women also reflected on a pattern where their male partners would come home, find cause to hit their wives, change clothes, and go out visiting girlfriends. Such patterns of violence have been associated with men's attempts to avoid accounting for their infidelity and to justify them continuing such practices [24]. A few South African studies have suggested that male multiple partnering is a form of emotional abuse [24, 229, 230]. In particular, an ethnographic study of ideal femininity in the rural Eastern Cape, South Africa found that male multiple partnering can impact negatively on women's sense of self and its effects are not recognized as abusive due to notions of male sexual entitlement that is legitimised and reproduced through social support for masculine ideals that celebrate men's sexual prowess [24]. Similarly, this study also shows that men's multiple partnering and financial negligence of wives and children are normalised to the extent that women are groomed through idioms and songs to expect, accept and tolerate these behaviours as normal masculine traits and expected features of men in relationships.

Some women were reportedly wary of engaging in sexual intercourse with their unfaithful male partners and indicated that some men forced them to have sex and women were under social pressure to meet their male partners' sexual desires and sometimes felt obligated to do so when

they did not want to. Forced sex by male partners with concurrent sexual partners was associated with some participants having had unwanted pregnancies. Women also regarded this behaviour as men's sexual control of their choice, sexuality, and fertility. The findings also confirms that some male partners used sex to exercise power and control over their female partners, sometimes to avoid being held accountable for their questionable behaviour [231], while other men drew on social norms related to men having multiple partners during their female partners' pregnancy. For instance, Dorcus described how she found out about her husband's infidelity during her pregnancies and breastfeeding period. Men are likely to take advantage of the social norms that prohibit sex with a highly pregnant or breastfeeding woman [24, 232].

Participants also identified factors influencing women's experiences of IPV, and these were multiple sexual partnering, men's alcohol consumption, and social and gender norms, among others. Multiple sexual partnering was commonly reported as the main cause of women's experiences of violence from an intimate partner. Women compared social beliefs and reactions to multiple partnering by gender, suggesting that compared to men's, women's multiple partnering was found objectionable by society and was perceived as a justifiable cause for IPV if a woman was caught cheating by her male partner. In some cases, participants reported that after confronting a male partner about having multiple concurrent sexual partners or asking him to use condoms triggered violence. Asking male partner to use condom, has also been found to elicit men's suspicions that their female partners were cheating, and such suspicions, in turn, triggered and violent reactions towards women [195, 227, 233]. Other women reported that they were more likely to experience IPV when their male partners were drunk [233].

SFL discussions on cultural beliefs and relationship practices contributed to a shift in women's gender attitudes. After participation in SFL, women had begun to interrogate and challenge social messages, norms, and practices they perceived to communicate social expectations on women to tolerate, excuse, and accept IPV. They believed this normalization of violence against women subjected women to IPV, condoned men's abusive behaviour while also silencing and isolating women. The findings also confirms that that tolerance of IPV was seen as a sign of a woman's perseverance, which is one of the key attributes of ideal femininity in marriage [24].

Gender norms and attitudes came into focus in the analysis as the findings indicated that male multiple partnering incited competition and rivalry among women for the same men as well as a judgment against women facing IPV or male infidelity. Women in the study condemned this and concluded that it was driven by gender norms and attitudes of men, women, and the community and ultimately denied women solidarity and support from other women and bolstered men to continue to behave badly. They discouraged other women from using wedding songs and idioms that carried messaging that support negative male behaviour and believed these messages served to promote abusive male behaviour towards women and blame women for men's bad choices.

There was also a gradual shift in women's responses to their experiences of IPV since their participation in SFL although with limited success in ending the abuse. Before participating in SFL, some women were reportedly more likely to seek help from family, neighbours, and friends than to report violence to the police. The traditional practice of reporting violent male partners to in-laws have been found less successful in resolving the violence [24]. Married women reported male partner violence to their in-laws and had found that step was not helpful as the husband's family usually defended him and blamed her. After SFL the older women were dismissive of the traditional guidance to resolve IPV by involving the in-laws stating that it offered limited help, condoned the abuse, and silenced and blamed women [24, 108]. Silence about the violence women experience has been associated with social shame and blame, fear of not being believed, fear of intimidation and retaliation by male partners or their families [234, 235] and women stay in abusive relationships due to pressure to make the marriage or relationship work and to avoid social marginalization [216, 236]. Participants found the in-laws reinforced notions of femininity to persevere and this displayed their complicity in perpetuating patriarchal values that sustained male practices to dominate and control women.

Women reported limited resources to respond to the violence they faced and even after SFL, most women were less likely to report abuse to the police or leave abusive relationships. Many women broke the silence for the first time by disclosing their violent experiences during SFL group meetings. Following SFL workshops, some abused older married or cohabiting women reportedly confronted abusive male partners and were successful in ending the abuse. These women attributed this to the communication skills learned from SFL which emboldened them to have frank

discussions about their experiences of violence from male partners and share anti-violence messages from SFL and these men reportedly stopped their violent behaviour. On the other hand, the findings show that while confronted with social and gender norms to remain in abusive relationships, a few women resolved to leave abusive partners even before attending SFL. The circumstances included when the male partner had a child with another woman while married, and after being threatened with a gun. One woman who left her abusive husband went as far as to challenge him by claiming child maintenance. Participants also indicated they applied lessons from SFL in their community by advising other women experiencing abuse. This is consistent with an earlier evaluation of the IMAGE project [38].

The study findings further suggest that women realized their contribution to women's experience of IPV as primary socialization agents of girls and young women particularly during bride grooming, idioms and wedding songs shared with women under the ambit of these messages as wisdom for marriage while they condone negative male behaviour that puts women at risk of IPV or HIV infection. Some further acknowledged that these deeply entrenched believes about the unequal positions and roles of women and men rob young married women of the support they need in their relationships. These realizations were also influenced by women's reflections on the effects of IPV on women and their children following SFL. Consistent with the literature, the findings point to abused women having experienced emotional distress in particular [26, 99]. They also acknowledged the negative effects of IPV on children as witnessing one's mother being abused can cause anxiety, depression, and decline in school performance [237], and it further influence IPV victimization and perpetration in adulthood [106, 186].

5.3.2 HIV prevention, testing, disclosure, treatment, and care

Participation in SFL appeared to have positive impacts on HIV prevention, testing, disclosure, treatment, and care among those with HIV and demonstrated the limited attempts women made to improve their sexual health. Women had improved their HIV and safer sex knowledge. Many had begun to share the information about HIV with male partners, children, family, and community members, and discussed HIV prevention and testing with male partners and children. Others went as far as giving their children condoms.

Women also reported somewhat improved agency in sexual decision-making though it was not without challenges and not completely effective after participating in SFL. The agency to make sexual decisions, including to negotiate safer sex with their partners and to use condoms, appeared to have increased. A similar finding was observed in the IMAGE evaluation [190] but this study amplified this was more common among unmarried women compared to married or cohabiting women and other studies concur [238, 239]. Condom use is associated with lack of trust, suggests infidelity and may result in violence in long-term relationships such as married or cohabiting [240, 241]. Other barriers to condom use, namely the notion that condoms reduce men's sexual interest and sexual pleasure [242], also featured in participants' interviews, and participants claimed that non-condom use was influenced by women's fear of male partners dating other women due to these notions about male sexual pleasure [239]. Lesser condom use among these participants may likely be related to the notions of ideal femininity that ascribe sexual passivity to women particularly those who are married [24]. After SFL, married women's inability to negotiate condom use may be explained by the idea that sexual decision-making remained in the hands of men despite their reported economic empowerment through the IMAGE component of the project. Such challenges are recorded in other studies [25]. Considering that women in the study were reporting improvements in their economic conditions through women-led IMAGE programme, their sexual decision making was undermined by gender inequalities associated with being married. However, these findings suggest a gap in SFL's ability to adequately impart ideas and skills for women to optimally exercise their sexual agency.

Few women had tested for HIV, but many women reported having had conversations with their male partners about HIV testing following SFL. This was commonly reported by many older and married women. A few women were able to convince their male partners to take the test and some HIV positive women used this opportunity to take the HIV test together mainly to facilitate disclosure of their positive HIV status. Consistent with established barrier to HIV status disclosure, women who delayed HIV disclosure to male partners and family members reported having done so for fear of blame, abandonment, accusations of infidelity, divorce, physical violence, loss of financial support from male partners, as well as fear of isolation, stigma, and discrimination [124, 243, 244]. Some women reportedly mitigated their difficulties with HIV disclosure by encouraging male partners to test and had their 'first' HIV test with the male partners. This strategy reportedly

helped to minimize backlash they anticipated from male partners for testing HIV positive. This supports the idea of a couple-centred approach to HIV counselling and testing [241, 245], and could form part of additional services provided through such combined gender transformative and economic empowerment programmes as IMAGE and SFL.

However, there were reports of some male partners resisting HIV testing. Male resistance to HIV testing has been observed in other studies and can be attributed to male perceptions of virility and their associated difficulty accepting physical vulnerability [216, 246]. Courtenay's relational theory claims that men and women adopt healthy behaviours that uphold the ideals of their gender identity and men apply certain health behaviour that demonstrates power and status within relationships and society, and if certain health behaviour threatened to undermine their gender position, they would resist doing so [246]. Furthermore, fear of testing HIV positive due to associated stigma and discrimination, and the lack of awareness of improved HIV treatment and free or low-cost care can prevent men from testing [247, 248].

5.3.3 Reflections on women's income, decision making roles, and leadership

Women in the study had an income-generating activity component provided by the IMAGE. This component of the project and has been found to increase access to income [39]. The study findings confirmed that participation in the economic empowerment initiative is instrumental in enabling women to access income to meet their personal and household needs and realize their full potential in diverse areas of their lives [249]. Earning income enabled participants not only to meet personal and household needs but also reported having begun to play a provider role and having increased personal agency in financial decision-making and to assume leadership roles in the community, despite sexual decision-making having remained in men's hands. The combined programme was further instrumental in addressing the economic abuse associated with a lack of financial support or abandonment by male partners. Women perceived their ability to earn income to have brought about a sense of pride and freedom to use their money the way they wanted. There also developed a dominant perception among women that their gender roles had shifted from housekeeping and childcare to become providers for their families and were thus equal to their male partners and should also be involved in decision-making across all matters within the household. This is plausible as other studies found that women's access to income improved women's control over

household finances and decision-making as they began to play breadwinner and leadership roles within their families and in the community [25]. Others see women's share of household income as a predictor of women's involvement in decision-making [250].

The findings also concur with the common view that men are generally considered leaders and therefore ultimate decision-makers over women [25, 251]. This manifested through perceptions that men should have a final say in all decisions and women's leadership was portrayed as disastrous. However, women in the study challenged the traditional conceptualizations that discredit women's leadership, questioned the norms that endorse men as heads of households and ultimate decision-makers, and considered themselves to be playing leadership roles within households and the community. Women's expressions of the need for equality with men extended to aspects that are traditionally believed to be a male prerogative such as negotiation of lobola [88, 252, 253]. This was indicative of women's attempts to challenge traditional gender roles following their participation in the SFL programme. However, this is notwithstanding that women had demonstrated leadership within households as single parents, widows or partnered women but the recognition had not always been there. Some argued that women make better decision-makers compared to men, stating that they made more sound financial decisions while men spend their income on their personal needs at the expense of their families and children. Women also were proud to use their income on a variety of small and big projects without asking for money or permission from male partners.

Despite the shifts in women's ability to lead and to participate in financial decision-making, women faced resistance from male partners, particularly towards the decisions they had begun to make in their newly acquired role as income earners in the home. When 44-year old Merriam used her income to surprise her husband with a new carport, she experienced backlash for not consulting him before doing so, even with her own money. Studies show that women's improvement in financial status challenges male control of financial resources and decision-making and men may use violence to gain control over women and this may increase women's risk to IPV [25, 216, 254]. Evaluations of the impact of women's microfinance programmes on IPV suggest that male partners not valuing women's income is also associated with an increased risk of physical and emotional abuse [226]. Some women faced ambiguity as they navigated between traditional housekeeping

roles and their newly acquired role in financial decision-making [216] and risked disharmony in relationships with husbands. However, these findings do not suggest a connection between women's improved economic agency and their experiences of IPV except the male resistance to women's economic agency reported. It also appears that communication skills and social support received from SFL may have also helped women avert violence from male partners [27, 38].

Undertaking all income-generating responsibilities in the household where male partners were unemployed brought about more challenges for women in the study and this was associated with deeply entrenched gender roles. The findings indicate that although a woman's male partner may be unemployed, she should not expect him to help with household chores while she is working and should come back home to resume all household chores instead as domestic work is perceived to be women's domain. This concurs with other studies claiming that men do not necessarily contribute to household chores despite being unemployed due to entrenched patriarchal norms applied in the sexual division of labour [21], and this has been referred to as the "double shift" [255]. Thus, it is evident that women reverted to submissive positions to express empathy for male partners' loss of work and income and their need for power regardless of the income belonging to women.

The study findings highlighted the SFL programme's limitations to effectively address gender roles as some women retained gender norms that uphold men as decision-makers which undermine women's agency, and further confirm that economic empowerment programmes require stronger gender-transformative content as women's gender attitudes and gender norms are not easy to change, and agency cannot be attained without overall gender transformation of male partners as well. This could be resolved by strengthening SFL sessions on violence, gender, and communication by increasing the length of sessions and considering the involvement of male partners in participatory gender-transformative programming even if women remain the key beneficiaries of income-generating activities [256].

The findings also indicate that some women had ascended to leadership positions like secretaries and treasurers of existing women's groups, as chairpersons of local school governing bodies and they attributed this to the skills acquired from participating in the SFL programme. Women

believed that the election of women into community leadership positions was a demonstration of the community's trust in women's leadership. This is a positive spinoff for this group of rural women as it acknowledges the capability of women to lead thus challenging patriarchal notions of leadership as exclusively for men [251] and recognizing women as potential agents of change within their communities. That communities elect women into local leadership positions may also be an indication of their appreciation that while women and men apply different leadership styles, neither one is dominant to the other [257]. It could also be an appreciation of women's leadership qualities such as empathy, good communication, and inclusive problem-solving and decision-making [257, 258].

5.3.4 Reflections on the role of femininity, marriage, and socialization

The findings also suggest that femininity was an integral part of women's reflections about the perceived effects of the SFL programme in women's relationships and personal and economic agency. In the community, being married was highly valued and marriage was seen as the ultimate and lifelong destiny for women to fulfil their gender roles. Lobola being given to the woman's family legitimized her married status [24, 87, 252] and afforded women higher social status and respect compared to unmarried, cohabiting or divorced women who were somewhat marginalized [24]. Married women were burdened with social expectations instilled in them before and after marriage by older women from their kin, affinal families, and communities. Wedding songs and idioms were mentioned as the key conduits for relaying gendered expectations particularly during bridal advice-giving ceremonies that are significant arenas where knowledge transference from the older to the younger generation of women occurs [259], as well as where the submissive role of women in marital relationships is emphasized [260]. While women in the study problematized the underlying messages in wedding songs and idioms sung during such gatherings, they serve to inform women of their roles and obligations and the ascribed behavioural characteristics of respect, obedience, tolerance, and servitude towards husbands and men in general, and the matrimonial family. As young married women, they are instructed to comply with these expectations in every area of their lives mainly by the mothers-in-law who also see young brides as relief from the burden of physical household labour [261], and are warned that failure would incite violence or divorce, which are often perceived as deserved and necessary for correction. Since marriage is considered the ideal attribute for successful femininity, unmarried women's success is measured with the

absence of marriage as the yardstick for failure [24]. Being married is perceived to give power to men and his family over the bride and this is supported by the idea that lobola grants men full control over their wives, and these notions provide fertile grounds for the condonation of men's abusive behaviour as women feel compelled to tolerate it [253]. These findings are supported by other researchers on heterosexual gender identities in South Africa [16, 24, 25, 253].

An important finding is that older women in the study had strongly challenged the content of wedding songs and idioms that communicate inequitable gender expectations and claimed the underlying messages were oppressive and unfair to women as the social expectations on women impressed upon them to tolerate and excuse negative male behaviour particularly male multiple partnering and IPV. Participants also critically reflected on how the song content communicates different messages to men versus women and how these incited gender inequalities within relationships [260, 262] particularly prescribing obedience and perseverance amid marital difficulties for women and the provider and protector role for men [260]. The underlying messages were further observed for placing the responsibility to make the marriage work mainly on women, not men, prohibiting divorce [259], encouraging women to accept, tolerate or excuse questionable male behaviour [260] and could explain why women stay in abusive relationships. Thus, these women realized their complicity with patriarchal norms [22, 24]. Women realized that supporting patriarchal values fuelled competition and divisions among women and this undermined their ability to build social capital. Their questioning of social messages that discriminate against women following these women's participation in SFL is noteworthy as it came from older women some of whom were mothers-in-law themselves. It also suggests SFL's relevance for older women to realize the unequal gender ideologies taught to them over a long time and highlights their potential to be agents of change in the intergenerational transfer of cultural norms and practices. Overall, these findings highlight the need to address gender inequitable messages embedded in social and cultural practices and the potential to use wedding songs and traditional ceremonies as platforms for intervention. These findings support the idea that SFL provides a platform for women to explore their culture including the content and meaning of wedding songs and common sayings [195], fosters critical reflections on the contribution of such messaging to IPV and HIV and builds women's agency to reflect and to influence change or challenge associated practices as part of prevention efforts.

Women had also identified good communication, quality time with male partners, respect, the absence of violence, sexual satisfaction for both women and men, fidelity, and love as the factors that would contribute to restoring harmony within relationships. Some confirmed that communication and problem-solving skills acquired from SFL, such as listening, patience, and managing anger, helped to restore relationship harmony as others reported having refrained from shouting at their male partners and instead engaged in constructive discussions to resolve problems. Similarly women also upheld sexual satisfaction as a major ingredient to maintain good relations with male partners even where communication is poor [263, 264], and this fed into the idea that poor sexual satisfaction of men leads to their infidelity and justifies male sexual entitlement. Yet, there is more to male multiple partnerships than men's sexual dissatisfaction with female partners. Consistent with established evidence, women in the study recognized that male multiple sexual partnering is associated with HIV acquisition and experiencing IPV [265-267]. The findings show that claiming sexual dissatisfaction brought social shame to women and some were under pressure to use vaginal drying agents to improve male sexual pleasure and prevent men from seeking other women [215]. After participating in SFL, women in the study reported having stopped using vaginal drying agents as they learned of its association with cervical cancer and realizing that the pressure to keep male partners or to prevent them from dating other women or to avoid conflict in relationships could also open women to engage in unwanted sex. In itself, unwanted sex is a form of sexual violence and may also result in HIV infection or unwanted pregnancy [268]. Women acceding to pressure to satisfy men's sexual demands can be linked to acquiescent femininity as women tend to excuse negative male behaviour [16]. Yet male multiple partnering forms part of a set of attributes associated with the dominant ideal black African masculinity which include men's demonstration of physical toughness, strength and sexual success [16] and women risking their sexual health to dissuade men from sexual conquest deeply entrenches and enables men to legitimize their sexual entitlement [269]. However, given the normativity of male multiple partnering, there is no guarantee that women can control male partners' behaviour or ensure their faithfulness but rather may lead to women's increased risk of HIV infection and experiences of IPV.

In addition to exploring barriers of supportive relationships among women, women in the study identified gossip, name-calling, and dating other women's male partners as denigrating women and incited unnecessary rivalry among women which strained relations among friends and female relatives [24]. Wedding songs and reciting idioms that convey support for men's infidelity were also identified as problematic and communicate women's complicity with the notion that men are entitled to have multiple sexual partners and drive competition among women while men are not held accountable for their misbehaviour [24]. One of the positive findings after women participated in SFL was consistent feedback that participants had realized their complicity with patriarchal values that privilege men and some women had reportedly refrained from doing so.

Women also garnered social support by engaging in local social savings, including the loan groups established to support women to sustain their income-generating activities. Social clubs have been found not to only improve women's economic status but also provides women with a platform to access and dispense emotional, material, and practical support to other women when they needed it and this fostered solidarity among them [39, 270]. Loan group meetings also enabled women to give and receive advice on business and financial issues, health, family, and related matters including childcare, bereavements, and intervention during relationship conflict and violent situations. Some women had taken further their SFL learnings on IPV and HIV and had begun sharing with other women in the community. The usefulness of establishing women's groups and the associated cooperation and solidarity among women were also perceived as critically important in supporting women during crises [38, 39]. Support received from social groups has also been found to contribute to the reduction in women's risk for emotional, physical, and economic violence [38, 226], and it is in these kinds of spaces that some women were awakened to the underlying meanings attached to the songs and idioms that condone male privilege and undermine women. The support dispensed to women in these spaces were also sustained by ensuring critical personal qualities such as confidentiality and trustworthiness as women recognized the common perception of women as gossipers and women endeavoured to work together constructively. Fostering trust and solidarity within groups as the basis for participation also has the potential to influence encourage women to join social networks [39].

The benefits of social groups may not have been enjoyed by all women participating in the SFL programme as other studies show that younger women (<35 years) are less likely to participate in loan groups [33]. This is concerning as this age group is the most vulnerable to IPV and HIV and consequently may miss out on the benefits of group support. In the current study, younger women reportedly did not trust they would be supported by other women in the community but had more confidence in support received from community structures such as community policing forums. Further, younger women's reluctance to participate in social supportive relationships groups could also be attributable to the social status associated with marital status as many of them were unmarried. Similar to other studies, the findings show that married women occupied the highest level in the hierarchical order of femininity in this community and thus had more social capital compared to unmarried or divorced [24, 271]. The perceived competition and rivalry among women is likely a barrier to women's participation in social groups and could also have been impacted by the social hierarchy that puts younger unmarried women in the lower social status and these women may have found it difficult to discuss experiences of partner violence as their relationships may have been seen as illegitimate since no lobola was given in their name by current male partners and younger unmarried women likely excluded themselves from these women's groups. This does not negate that other barriers such as household and childcare responsibilities could have stood in the way of these women joining local social groups with other women [226]. Addressing some of the concerns shared by women regarding gossip, loan repayment problems, financial mismanagement of loans issued for the IGAs, and group leadership challenges could have reduced the barriers to women's participation in loan groups and strengthened their social capital in the community. The findings suggest that strengthening social empowerment initiatives like SFL may be useful to sensitize women about the influence of social and gender norms and their contribution to the oppression of women and help them recognize how their attitudes may hinder social support among women and begin to contribute towards positive social change. Mayoux suggests that promoting women's participation in social groups and more strategically group-based economic and social empowerment initiatives could strengthen social networks [272].

5.3.5 Sexual and reproductive health

The SFL programme appeared to have provided accurate information about the physiological process behind menstruation as women asserted that they heard this information for the first time

from the programme. It further provided clarifications about women's sexuality and enabled women to break the silence and secrecy about women's menstruation, sex, and sexuality and further contributed to women's improved understanding of their menstrual experiences, the ability to calculate the menstrual cycle and participants reportedly transferred this newly acquired knowledge to their daughters. The findings also indicate that participation in SLF has the potential to influence a shift in attitudes and practices against inequitable gender and social norms that entitles men to sex over women and improved women's agency to assert sexual decision-making in intimate relationships.

Women in the study reportedly did not know the actual physiological function of their bodies behind the menstrual cycle as they mentioned a lack of accurate information about the female body. This contributed to misconceptions and myths including the notion that menstruating women are dirty and explain some of the women's perceptions that discussing menstruation and sex is taboo (Manabe 2010). Such beliefs were also obvious during the SFL workshops as some older women flinched during sexuality discussions and displayed their discomfort about direct talk about menstruation and sex. Social discomfort with sexuality communication may explain an evident culture of silence among women about specific aspects of female sexuality which could increase women's agency over their bodies, while there are social dictates over how women should use their bodies [89].

Women's reflections also indicated that social messages portray menstruation and women's sexuality as mysterious, unexplainable, a secret that is not open for discussion and that talking about them is taboo, yet women's compliance with vague messages is critical [273, 274]. Women further discovered that menstruation and sex are a natural part of the woman's reproductive cycle that women should expect to experience yet social norms seem to communicate deceptive information. They further realized that social sexual expectations of women are constructed to meet men's sexual desires rather than to benefit women as well [268] and these notions expose women to the risk of HIV and other STIs. It is plausible that the silence and misleading information over women sexuality could have been to suppress women's sexual needs and agency and to enforce submissiveness, passivity, and women's compliance with the prevailing norms to use their sexuality to benefit men thereby creating an imbalance in their sexual interactions [89]. This

finding confirms that power imbalances in heterosexual interactions can lead to a culture of silence among women about women's sexuality [268].

Furthermore, the silence and secrecy around women's sexuality deprive women of access to accurate information about menstruation and the sexual experience [275]. Consistent with these findings, the lack of information may compromise women's sexual agency by limiting control over their sexual interactions and may increase the risk of sexual violence and STIs [268]. The findings also confirm the influence of social and gender norms on women's conceptualization of their sexuality [89]. Inequitable social and gender norms around sexuality uphold patriarchal values of male dominance over women's sexuality. They enforce silence and misleading information about women's sexuality and contribute to a misconception about their reproductive processes. It was only later in age, usually after women in this study got married and had had children that they discovered certain details about sex and sexuality that the elders held back from them.

The lack of accurate information had an impact on women's conceptualization of menstruation and contributed to misconceptions and myths about menstruation and sexual experience. This further compromised women's agency and control of sexual interactions, exposing them to sexual violence and STI and risky sexual practices such as dry sex, of which following their understanding of the risks entailed, women reported to have stopped these practices. Furthermore, pressure from sexual expectations from women to ensure sexual pleasure for men, coupled with misconceptions leads women to engage in risky sexual practices like dry sex as women likely may not understand, for instance, why women have vaginal wetness during sex and impede their sexual enjoyment, undermines their ability to challenge perceptions that vaginal wetness is problematic and is an embarrassment for women and that vaginal dryness is preferred to enhance male sexual pleasure [215]. These women's post SFL reflections on social and gender norms related to women's sexuality and sexual expectations demonstrate a shift in women's attitudes against such norms [276, 277]. Norms around women's sexuality were perceived to compromise women's agency in sexual decision making; therefore, placing the control of women's sexuality in men's hands. Women were determined that they should make their own sexual decisions and their decisions should be respected by their male partners. However, they highlighted that improved economic status is instrumental to enable women to make sexual decisions. Women reported having made

some changes due to the newly acquired information from SFL particularly improved understanding of the menstrual process, the sexual experience and improved practices including refraining from using vaginal drying agents. Some women also did pap smear tests to screen for cervical cancer, thus suggesting that the SFL programme may have positively influenced women's sexual practices.

5.3.6 The limited shift in attitudes and practices towards gender norms

A key finding in this study is that not all messages and lessons from SFL were retained and did not directly result in a shift in women's attitudes and practices towards inequitable social and gender norms across various learning areas. Fewer older women were of the view that the modern dress code increases the risk of rape for young girls, some held the belief that women should be sexually attractive to men, whereas there are no similar expectations for men. This may have influenced women's conceptualization of sexual expectations before SFL that they should ensure sexual pleasure for men. Some women held judgemental attitudes towards women who engage in transactional sex without challenging men's roles and use of power in those relationships.

Furthermore, although women were economically empowered and adopted positions of control over household finances; this role change did not affect change in women's gender roles, women continued to undertake housekeeping roles and it resulted in women's dilemma to balance traditional and progressive roles. Most women of all ages and marital status believed that they should not challenge men's authority but should remain submissive to men to avoid violence. Some women particularly younger and cohabiting women felt it was inappropriate for women to participate in household decision-making as they perceived that is reserved for men as heads of households. Such women's attitudes are complicit with ideals of femininity, uphold the dominant patriarchal norms [24] and undermine the goal of SFL of gender equity. Jewkes and Morrell observed a similar phenomenon where women did not challenge male partners nor existing norms that enforce ideals of femininity [16, 17]. Such limitations in shifting gender norms and attitudes that put women at risk of HIV infection and IPV can be attributed to a lack of economic resources to improve women's agency to challenge such norms, therefore highlighting the need for combined programming [39, 190]. However, these findings indicate that more research and intervention

strengthening is needed to understand the difficulties in changing gender norms among women undergoing economic empowerment programmes [30].

5.4 Emerging lessons

The study findings confirm that participants found SFL to be an important and informative training programme that is relevant to women's lived realities. Its participatory approach fostered sustained participation. However, some of its topics were sensitive and triggered emotional discomfort which may limit participation. The role of male facilitators needs to be investigated in future research to understand how it affects women's participation.

Consistent with the SFL goals the findings also suggest that participation in SFL has enabled women to make critical reflections and to challenge and act against gender norms. However, the findings also show that doing so is not easy to achieve in an environment that may still be patriarchal particularly among young women. Therefore, bringing a family focus to microfinance programmes that are combined with gender transformation may ensure that the gender norms change is more sustainable [256, 278].

It further suggests the feasibility and sustainability and effects of the SFL scale-up model. Demonstrating the potential feasibility and sustainability of the parallel model for the delivery of IMAGE intervention by a Microfinance organization and NGO.

The study suggests that older women are potential social change brokers within the relationship, households and since older women are custodians of culture and socialization agents programmes have an opportunity to use older women to influence a shift in norms and practices that can have sustainable impact for the future generations.

CHAPTER 6: CONCLUSION, CONTRIBUTION, AND RECOMMENDATION

6.1 Study contribution

The study contributes to the currently limited body of knowledge about the degree of input and significance of gender norms and HIV training when combined with economic empowerment programmes, towards HIV and IPV prevention. Furthermore, it is one of the limited studies that explore the effect of an intervention as experienced and perceived by the participants.

Specific contributions of this study to the body of knowledge are as follows:
Consistent with the SFL's primary goal to prevent IPV as a risk factor for HIV, SFL plays a significant role in IPV and HIV prevention. The study contributed to literature that explicates the limited effect of biomedical and behavioural interventions in preventing IPV and HIV. Women explored several topics which demonstrate that the intervention grabbed women's attention as they found the intervention relevant to their experiences in relationships with men in terms of IPV and HIV prevention. This shows that addressing structural issues such as women's positions in relationships and at home may influence their risk for HIV including IPV.

Also, this demonstrates the SFL programme is a relevant and acceptable intervention because there was a lot of good recall about the aim of the programme retention of lessons/messages and women took practical steps from the HIV testing, disclosure sessions and found safe ways to ensure their health. It also shows that gender norms programmes can work well not only to educate but also to help women reflect on their own lives, months after the SFL suggesting potential sustainability of the impact of SFL.

The study provides further evidence of the need to address the broader structural factors such as gender inequalities in addition to improving women's economic conditions in the context of preventing HIV infections among women.

The findings illustrate that integrating gender norms change with economic empowerment programming is essential for HIV prevention as both gender and economic inequalities contribute to and perpetuate violence against women, a key risk factor for HIV infections among women including poverty transactional sex, multiple sexual partnering, low relationship power, violence. All these contribute to a limited agency in sexual decision making. Doing so is a valuable strategy with potential medium to longer-term and inter-generational payoffs. As seen in this study, workshops encourage women to critically reflect on inequitable gender norms, find ways to improve their agency and household decision-making, and learn skills that enable them to assert themselves with partners, for instance, to negotiate safer sex and to act against IPV, albeit with limited evidence.

Findings show that women started looking at the messaging from wedding songs and idioms and wanted these to be more gender equitable. Therefore, the programme will enable women as socialization agents to socialize young women and boys into ways of being a woman and a man or wife and husband that correspond with more equitable gender norms. These will contribute to the reduction in the levels of violence in the coming generations.

The study further suggests that older women are potential social norms changers and HIV prevention brokers within their communities. They are recognized as custodians of social norms and practices, they are the primary enforcement (socialization) agents as wives, mothers, aunts, grandmothers, and mothers-in-law in the community.

Exposure to gender training interventions enables women to make critical reflections on the inequitable gender norms that increase women's vulnerability to IPV and HIV and enable them to critically reflect on their role as socialization agents and their complicit role in the intergenerational transfer of cultural norms. As such they are placed in a unique and strategic position to lead the change from reinforcing emphasized femininity and complicity with patriarchal norms which expose women to increased risk of HIV and instead to socialize young girls and young women towards more equitable gender norms that promote gender equality within relationships at household, community level and across generations.

The study also demonstrates the difficulties involved in changing gender norms. Nevertheless, SFL enables participants to make critical reflections, to retain messages and to effect shifts in attitudes, and to apply lessons in practice or to act against inequitable gender norms with varying levels of success. However, the process is not linear as various factors influence the process and that the desired impact is not guaranteed. Therefore, the study highlights the need for more research to understand the impact of these gender norms changes interventions on women.

The SFL programme contributed to filling the knowledge gap women had about their sexuality. Their lack of knowledge undermined their agency for safe sex practice and subjected them to risky sexual practices e.g. dry sex and sexual exploitation like engaging in unwanted sex, both of which risked their sexual wellbeing. It, therefore, highlighted the importance of women knowing and owning their bodies to be able to adopt healthy sexual behaviours.

Participation in the matched economic empowerment programme was associated with an improvement in women's economic wellbeing, particularly women's ability to meet basic personal and household needs. This improved women's participation in financial decision-making. The findings show a shift in gender roles and leadership among women. The study further contributed to an understanding of how women put lessons learned into practice, how easily they can do that, what they do when they face challenges and how they deal with the opportunity that economic empowerment brings them.

SFL facilitates HIV preventive practices such as negotiating safer sex and HIV testing with male partners and accessing HIV treatment. It also addressed women's risky sexual practices. Therefore, the study suggests that gender and HIV training are worthy accompaniments to economic empowerment. The study revealed that some women could negotiate condom use with their male partners, but this was dependent on their age group. Some were able to do HIV testing with their male partners; some found the courage to disclose their status but did so in ways that protected themselves. Women needed to do this sometimes since partners often saw them as the cause of the HIV infection. Furthermore, the SFL programme found a non-judgemental way of addressing women's own risky practices such as vaginal drying agents, multiple partnerships, and improving their sexual health like taking a test for cervical cancer.

The study contributes to the literature that explicates the limited efficacy of biomedical and behavioural interventions in preventing HIV. SFL provided a platform for and has enabled participants to critically reflect on the role of gender and social norms in shaping individuals' behaviour that increases the risk of IPV and HIV and that undermines their agency to adopt safer sexual behaviour. Participation in SFL is associated with a shift in attitudes and, to a certain extent, practices away from inequitable gender norms.

6.2 Conclusions

The study highlights SFL as an invaluable and enlightening life-changing training that provides relevant factual information and practical parental-like guidance to women about issues they face in their everyday life. Its participatory method, coupled with skilful facilitators, makes it enjoyable and encourages participation and attendance. Matching of participants to facilitators by gender and age must be considered to increase participants' comfort during sessions.

The study demonstrates that SFL was effective in providing an opportunity for women to reflect on how inequitable gender and social norms embedded in the social and cultural life, like lobola and bride grooming, condone negative male behaviour towards women and socialize women to be complicit and to acquiesce to this behaviour. It also enabled them to consider the degree of unfairness and oppressive nature of these norms towards women as the norms do not apply equally to men and can be the underlying driving force behind women's vulnerability to IPV and HIV infection. The findings emphasize the need for interventions to prevent IPV and HIV infection to prioritize addressing those social and gender norms.

SFL also facilitated improved knowledge about forms of IPV that participants had not previously classified as abusive. Instead, they had been socialized to accept them as a normal part of a relationship, namely male multiple partnering and the lack of financial support from a male partner for his wife and children. SFL also enabled women to break the silence and begin sharing their violence experiences with other women thus accessing circles of support. Some women became the go-to people for advice on how to deal with IPV in the community. While women reported having the capacity to act against the violence they experienced from male partners, the extent to

which women acted against abusive male partners was varied. Yet, some women employed effective communication strategies to address the abuse directly with male partners. SFL worked well in encouraging women to critically reflect on social and gender norms that promoted the oppression of women in relationships and prevented women from receiving social support and to explore their role and complicity in perpetuating these norms.

SFL also played a significant role in getting participants to apply lessons on HIV prevention, disclosure, treatment, and care, and to do so in ways that maintained their safety and improved their sexual health. The programme also filled the gap in the knowledge about women's sexuality thus highlighting the importance of women knowing and owning their bodies to be able to adopt healthy sexual behaviours and assert sexual decision-making in intimate relationships where women are expected to be sexually submissive to male partners. The SFL programme enabled women to observe how they had economic agency and how they used their financial resources. It also exposed the male resistance some women faced. While women grew in stature around financial decision-making and leadership, resistance by male partners remains a challenge.

6.3 Recommendations

The study contributes to demonstrating the effectiveness of programming that combines behavioural and social norms change intervention with economic interventions for effective HIV prevention. It highlights the need for the development of similar programmes as well as the strengthening and scaling up of existing programmes. However, SFL has areas that also require attention by researchers and programmers to ensure that they are more effective in addressing HIV and IPV prevention and contribute to the economic empowerment of women in South Africa. The recommendations are as follows:

- The study demonstrated some limitations in SFL's ability to ensure participants retained key lessons and applied the learning effectively. This was evident in how young women were not able to act effectively against the violence they experienced at the hands of male partners compared to older women. This highlights the need for SFL to explore the strengthening of the domestic violence session to provide skills that would apply to both younger and older women.

- The intervention is aimed at empowering women to reduce HIV infection and address its risk factors including IPV and poverty, thus it is imperative to ensure the programme is delivered by female facilitators to ensure participants are comfortable and discuss sensitive topics freely. Programmers must explore dividing participants by age groups as well for similar reasons.
- SFL delivery must also reflect standard ethical considerations and this can be done by having an accessible and well-coordinated referral system as part of the SFL programme to ensure that participants are provided with safe spaces to address recall of painful events related to domestic violence, contracting HIV, disclosure and other challenges that they may be facing in their lives.
- The intervention needs to be strengthened to be more effective in changing social and gender norms among women as some continued to have judgemental attitudes against women who are raped or involved in transactional relationships with men. A revised manual should also explore elements of women's complicity with inequitable gender norms and practices, to build on the positive impacts reported by women in this study. Doing so has the potential to encourage solidarity and increased social support for women facing IPV and gender inequality in their relationships with men.
- While the shift in women's economic roles is suggestive of a progressive step towards gender equality, however, it did not liberate women from the burden of domestic roles and subjugation to male dominance as it was not always matched by men's cooperation in household chores. The programme should consider a couples programme to support women benefiting from economic empowerment interventions such as these [256]. This may provide women with the platform to address other areas of their lives that are undermined by male partners, for instance, sexual decision-making.
- More research and intervention strengthening are needed to understand the difficulties in changing gender norms among women undergoing economic empowerment programmes.
- There is a need to develop more similar programmes or scale-up similar existing programmes that combined behavioural and social norms change intervention with economic interventions towards effective IPV and HIV prevention.
- Programmes need to standardize assessment of participants' experience and perceived effects as a standard part of the monitoring and evaluation of the programme. This is critical to inform

necessary adjustments to ensure the programme is participant-friendly and to improve participation and effectiveness or achieves the desired impact.

- Interventions need to be tailored to accommodate the needs of younger women (<35years) to improve their participation. Younger women are more vulnerable to IPV and less likely to be able to take action against violence, yet they also face barriers to participating in programs from which they could benefit. Therefore, it is important for programmers to take into account barriers applicable to younger women and to tailor programmes to make them accessible for younger women to participate and retain them for the duration of the invention.

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APPENDICES

Appendix 1: Interview guide

Study ID: __ __ __

Study: Experiences and effects of participating in Sisters For Life (SFL).

Section A: Participant's experience of participation in SFL.

This section will explore experiences of what it was like for participants to practically undergo the SFL training.

- Tell me about yourself.
    - Age, family, children - if any and ages, size of the household members.
- What is SFL in your own understanding?
- How did you come to participate in SFL?
- What it was like for you to take part in SFL training?
- For how long have you been participating in SFL?
- Tell me about your participation in SFL.
    - When did you join?
    - In which centre?
    - How many sessions have you attended?
- What are your thoughts about the manner it was delivered?
- What was covered during the training?
- What was your role/responsibilities (if any) within SFL?
- Did you find anything useful about SFL? What did you like most about SFL?
- Did you find anything least useful or challenging about SFL?
- What would you suggest should be done differently (if anything at all) and how it should be done?

Section B: Participant's perceived effects of participation in SFL on different aspect of their lives.

This section will focus on participant's views about things they regard that they happened as a result of their participation in SFL intervention and it will explore the following aspect from participants:

- I would like to hear from you what you think of the SFL intervention and how it affected your life.
    - How would you say it influenced your attitudes towards?
        - your life,
        - your community,
        - your family,
        - Your relationships with friends, at home or with partners?
- How would you say it helped you in any of these areas of your life? Explain why you say so.
- How would you say it did not help? Explain why you say so.
- Let us talk about your thoughts about the role of women in your community?
    - What role do you think women should play?
        - What role are they currently playing?
        - What are your thoughts on this?
- What are your thoughts about women's access to income or money? Explain why you think so.
    - How has SFL affected you in this regard?
- What are your thoughts about women's ability to influence decisions at home, in the community or in intimate relationships?
    - Are women able to influence decisions made in the home, in the community or in intimate relationships?
    - Should they be able to make decision? Under what circumstances should it happen or not happen?
    - Explain why you think so.
- What are the things that you were not able to do before that you are now able to do as a result of participating in SFL?
    - In your home,
    - in your intimate relationship,

    - in the community, or
    - Any other area of your life?
- Tell me about your intimate relationship.
    - Are you currently in a relationship or recently were in a relationship?
    - Tell me about the good time in that relationship.
    - Tell me about the bad times in that relationship. What happened? Was there any conflict? Was this before or after your participation in SFL? How was it resolved it?
- Tell me about your thoughts about HIV since you began to participate in the intervention.
    - Have you used any information you learned in the workshop in your life if so how?
    - For example, in your communication, behaviour, prevention, HIV testing, HIV treatment?
- Tell me about problems you experienced in your life in the past year. What kinds of problems?
    - How did you handle them? Would you have handled it differently before SFL and how?
- Tell me about your Relationships with other people in your life or in the community.
- Do you have people you feel you can trust? Tell me about them.
    - What kind of support do you receive from them? What kind of support do you provide to others?
- We are about to conclude our interview. Is there anything that I did not ask about the changes that happened that you would like to say or talk about? If yes, please say it.

Appendix 2: Participant Information sheet

Study ID: __ __ __

Experiences and effects of participating in Sisters For Life Gender and HIV intervention

Introduction

Good day, my name is Lufuno Muvhango. I am a postgraduate student from Wits University.

I invite you to consent to participate in an interview as part of study on experiences and effects of participating in Sister For Life (SFL) to find out more about your experiences and views of Sister for Life. This information sheet will help you to decide whether you want to participate. You should fully understand what is involved in this study before you participate. You don't have to say YES right away; if you have any questions that this paper does not fully explain, please do not hesitate to ask me.

The meaning of "giving informed consent".

- *It means that you understand what this study is all about and that your freely agree to participate in this study*
- *That you understand all the things that we will ask you to do as part of this study and you are happy with them*
- *That you know that you don't have to agree to participate in this study and that no one will be cross with you if you don't want to participate in this study.*

Nature and purpose of this study

I invite you to take part in an interview about your participation in SFL from when you started until the end and changes that you have seen in your life as a result of your participation in SFL.

Procedures that will be followed

I will ask you to participate in an interview asking about your experiences of taking part in SFL and what you see as things that happened as a result of your participation in SFL. The interview will take approximately 1 hour. The interview will take place in a private space where no one else will hear what is said. I have prepared a guide for some of the questions to ask you in this interview. I will write down some of your responses, but I would also like to record the interview using a digital recorder. I would like to tape record interviews so that I can accurately record what is said in the interviews. You will be given a separate form to indicate whether you agree to being recorded or not. If you agree to participate in this project, I will then give you 2 forms, the first one to agree to the interviews, and the second one to agree to have the interviews or discussions recorded.

Costs involved

If you agree to participate in the project, doing so will not cost you anything.

Risks or discomforts
At the present time, we do not see any risks in your participation. However, some of the questions may make you feel sad or upset to think about. If that happens, kindly inform me. You must feel free not to answer or talk about things that you are not comfortable with, and no one will be upset with you. If you agree I will refer you to the relevant service providers who might be able to help you to deal with your concerns at no cost.

Possible Benefits of this study
There are no direct benefits to you from participating in this study. Instead the information you share in this study will be extremely helpful; it will be collated with the information from other participants and be used to develop ways to improve SFL to benefit other women in future.

Your rights as a participant
Your participation in this study is completely voluntary. You can refuse to participate or stop participating at any time without giving any reason and there will be no negative consequences to you.

Confidentiality
Participation in the interview is between you and me. We will have interviews in a private space to ensure that there is no other person who hears what we discuss. Any study records that identify you will be kept confidential in a locked file cabinet and will not be available to others. I will use unique study codes to protect your identity and will use pseudonym (another name) in any publication.

Ethical approval for the study
This research has been approved by the Wits Human Research Ethics Committee (Medical). The committee will continue to see if this study is being done in a safe way from beginning to its completion. I have copies of approval letters from the ethics committees that show that the study was approved by them. I can give it to you if you wish to have one.

Contacts if you have been harmed or have any other concerns
If you have any complaints about ethical aspects of the research or feel that you have been harmed in any way by participating in this study, please feel free to contact the Chairperson of Wits Human Research Ethics Committee (Medical) at: peter.cleaton-jones1@wits.ac.za or call administrators: MS Zanele Ndlovu or Mr. Rhulani Mkansi or Mr. Lebo Moeng on this telephone number: 011 717 2700/2656/1234/1252. You may also send an email to: HREC-Medical.ResearchOffice@wits.ac.za or call the WITS Ethics Committee hotline 0800 212 123.

Information and contact person
If you have any questions or concerns about this study, please contact the researcher, Lufuno Muvhango on 011 268 0576 or 076 557 5533.

Appendix 3: Consent form

CONSENT FORM FOR INTERVIEW

I hereby confirm that the person asking me to participate in research on the experiences of SFL intervention has given me information to my satisfaction.
She explained to me the purpose, things that are involved, risk and benefits and my rights as a participant in the study. I asked questions and I am happy with the answers I have been given regarding participation in the study. I have been told that the information I give to the study will together with other information gathered from other people, be written into a report and scientific publications. This will be done without my name and any other thing that could identify me as a participant in the study.
I am aware that it is my right to refuse participation in this study without experiencing any harm. I hereby, freely and voluntary give my consent to participate in the study.

I have received signed copy of this informed consent agreement.

Participant's name …….……. (Please print)

…….. …….
Signature of Participant Date

If you as a participant do not have a signature, please put X here ……

Witness's name ……..... (Please print)

…….. …….
Signature of Witness Date

If you as a witness do not have a signature, please put X here …..……

PERSON OBTAINING CONSENT
I have fully explained everything about the research to the participant and am satisfied that the participant demonstrated understanding of the research and is giving consent voluntarily.

Researcher's name……. (Please print)

Researcher's signature…… Date……

Appendix 4: Audio recording consent form

INFORMED CONSENT FOR AUDIO-TAPING OF INTERVIEW.

I hereby confirm that the researcher _____has requested my consent to audio-tape the interview. The researcher has informed me that the information I give on the interview will not be known by other people except the researchers and that only people who form part of the research will have access to the audio-recordings. I am aware that audio recordings will be destroyed after two years since the completion of the study or kept for up to 6 years if the study findings have not been published.

I am aware that my name including personal details will not appear in the transcripts resulting from the interview. I understand that I may refuse my interview being audio-recorded and that I will not suffer any negative consequences for that.

I voluntarily give consent that my interview be audio-recorded.

I have received a signed copy of this informed consent agreement.

Participant's name…….. (Please print).

Participant's signature……Date……

If you as a participant do not have a signature, please make an X here……..

PERSON OBTAINING CONSENT

I have fully explained everything about the research to the participant and am satisfied that the participant demonstrated understanding of the research and is giving consent voluntarily.

Researcher's names…… (Please print)

Researcher's signature…… Date……

Appendix 5: Ethics certificate

R14/49 Ms Muvhango Lufuno

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M161191

NAME: (Principal Investigator)	Ms Muvhango Lufuno
DEPARTMENT:	School of Public Health Villages in Ngaka Modiri Malema District, Mahikeng North West Province Intervention with Microfinance for AIDS and Gender Equity
Programme	
PROJECT TITLE:	Experiences and Perceived Effects of Participating in the Sisters for Life Gender and HIV Prevention Intervention in Mahikeng Municipality, North West Province, South Africa
DATE CONSIDERED:	25/11/2016
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Nwabisa Shai
APPROVED BY:	Professor P. Cleaton-Jones,Chairperson, HREC (Medical)
DATE OF APPROVAL:	01/03/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 10004,10th floor, Senate House/2nd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/We fully understand the the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated,from the research protocol as approved, I/we undertake to resubmit to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. in this case, the study was initially review in November and will therefore be due in the month of November each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

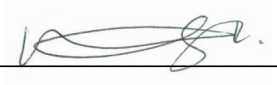
Appendix F: Plagiarism declaration report

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS SENATE PLAGIARISM POLICY:

I __Lufuno Muvhango _____ (Student number: ___0616969E_____) am a student registered for the degree of ___Master of Public Health (Mph)__ in the academic year __2019___.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

Signature:  Date: _____18 November 2020_____